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ABSTRACT

This is the final report on the first phase of a two phase comprehensive study of the delivery of Department of Health, Education and Welfare (DHEW) services to ethnic minorities. Phase one of the study was concerned with the extent to which services were delivered to Asian Americans, American Indians, and Spanish speaking people. The study sample included six states: Arizona, California, Colorado, Illinois, New York, and Oklahoma. This report presents a summary of an eight volume report. It presents profiles on Mexican Americans, Puerto Ricans, Asian Americans (Chinese, Japanese, Filipinos, Koreans, and Samoans) and American Indians, living on and off reservations. These profiles emphasize three points: That all of the ethnic minority groups have serious needs and problems with their health, education and welfare; that because each ethnic group is unique, services must be delivered to each group in an individualized and culturally sensitive manner; that each of the communities studied had serious complaints about the availability and method of delivery of services, as well as about the lack of cultural sensitivity and ethnic minority staff in Department of Health, Education and Welfare (DHEW)-funded programs at the local level. Summaries of in-depth studies of nine DHEW programs are presented. These programs are: Hill-Burton program, Medicare, maternal and child health services, community health centers, vocational education, bilingual education, educationally deprived children Title I, ESEA, Rehabilitation Services Administration, Head Start. (Author)

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Department of Health Education and Welfare
Services to Ethnic Minorities
Contract: HEW OS-72-209

PHASE I FINAL REPORT

UD016688

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I. INTRODUCTION

Urban Associates, Inc. (UAI) has been contracted by the Office of Special Concerns (OSC), Department of Health, Education and Welfare (DHEW), to conduct a two-phase comprehensive study of the major barriers to delivery of DHEW services in a culturally relevant manner to the Spanish Speaking, American Indians, and Asian Americans. Phase I of the study was limited to four months and was designed to: (a) survey the parameters of the problem; (b) identify major problem areas; (c) make an overall assessment of the degree to which ethnic minorities obtain their fair share of culturally relevant services; and (d) identify the major barriers involved. Phase II of the study will be 12 months in duration and is designed to follow-up on selected specific findings of the Phase I effort for purposes of in-depth evaluation and/or remedial action.

The initial Phase I report consisted of eight volumes and several hundred pages. The following report represents a compression of the major findings obtained in Phase I and is issued as the Final Phase I Report.

Because of the short duration of Phase I (4 months) a definitive study of national data was not possible. Only data that was readily available could be examined. Six states were selected as representative samples, based on the distribution of Indians, Asian Americans, and Spanish Speaking within those states.

The population of the six states selected includes 42% of the Indian population; 55% of Asian Americans; and 60% of the Spanish Speaking of the United States. In addition, the city of Hoboken, New Jersey was added in order to obtain data on a local community with a high concentration of Puerto Ricans outside of New York City.

The six states comprising the national sample utilized in Phase I were:

Arizona
California
Colorado
Illinois
New York
Oklahoma

In addition, 20 local communities distributed among the six selected states (and Hoboken, N.J.) were examined to identify specific problems in employment and services for ethnic minorities at the local level. Local communities on which data were requested are:

Arizona: Tucson County
Flagstaff
Navajo County

California: San Francisco
Tulare
Los Angeles
Imperial
Salinas

Colorado: Denver
Pueblo
Montezuma
Alamosa

Illinois: Chicago
Sterling

New York: Bronx County
New York County

Oklahoma: Tulsa
Adair
Caddo

Ethnic consultants, knowledgeable of each of the ethnic groups and subgroups, researched the literature; analyzed the data and studies available; contacted major organizations and agencies representing the interests of and/or servicing the ethnic minorities to obtain community attitudes toward major DHEW programs; and defined the major cultural characteristics of each group and subgroup. The consultants were asked to identify major gaps in information and services based on their informal surveys.

DHEW Offices and Programs were asked to cooperate by making available to OSC state plans, staffing patterns for state agencies, evaluation data, funding allocations and procedures, as well as, selected information on the selected DHEW programs which were studied during Phase I of the study.

Phase I, essentially exploratory in nature, was designed to define the parameters of the problem and to identify the major types of barriers which result in ineffective delivery of culturally relevant DHEW services to the three ethnic groups. The report is not and was not intended to be a comprehensive profile of ethnic minority populations, a comprehensive evaluation of the selected programs or a comprehensive study of management systems within DHEW. The material in all three sections is confined to information which contributes to an initial analysis of the relationship between ethnic minorities and DHEW.

Each office of DHEW, i.e., Office of the Secretary (OS), Office of Education (OE), Health Services and Mental Health Administration (HSMHA), Social and Rehabilitation Services (SRS), Social Security Administration (SSA), provided UAI with a liaison who was responsible for gathering the various materials, data, reports, internal memoranda, etc., requested. Cooperation at all levels was excellent and all offices and programs endeavored to provide the requested information, although a number of problems, not unexpectedly, were encountered.

On the basis of the findings in Phase I and the recommendations and areas of interest of OSC, Phase II will pursue in greater depth several areas identified, and will undertake field investigations and accumulate original or new data as appropriate.

II. ETHNIC PROFILES

A. Overview

The first section of this report consists of profiles of the different groups and subgroups which constitute the ethnic minority population which was the subject of the study. The section presents profiles on Mexican Americans and Puerto Ricans; a composite picture of Asian Americans, and the five major subgroups - Chinese, Japanese, Filipinos, Koreans, and Samoans; and a profile of American Indians, living on and off reservations.

The profiles presented here are not intended to be a comprehensive description of the groups. More complete pictures are contained in the Volumes III-V prepared by the ethnic consultants of the Initial Phase I Report. An in-depth portrait was not feasible, given the four-month period allotted for Phase I.

(One of the tasks of Phase II is to develop more comprehensive data on the ethnic minority groups.) The purposes of the profiles in this report are more limited. They are focused to emphasize three points:

1. That all of the ethnic minority groups have serious deficiencies in the areas of health, education, and welfare; deficiencies which flow from impoverishment, cultural differences, or, most often, a combination of both; and thus have substantial need for the services DHEW is committed to provide for all Americans.

2. That each ethnic group is unique, having a different language (or languages), life style, and world view and differing kinds and degrees of need for various services, such that, for each group, separate, individualized and culturally sensitive planning and delivery vehicles are necessary, if their needs are to be adequately met.
3. That contact with community agencies by the ethnic consultants during Phase I, indicated that each of the communities complained about serious problems in the availability, method of delivery, the cultural sensitivity and the presence of ethnic minority staff in DHEW-funded programs at the local level.

The information in the ethnic profiles comes primarily from the reports prepared by ethnic consultants employed by Urban Associates (UAI) during Phase I.

II. B. Spanish Speaking¹

1. Overview

The 9,294,509² persons of Spanish origin in the United States constitute 4.6% of the country's population. Mexican Americans represent 57% of the total group; Puerto Ricans, 17%; Cubans, 7%; Central and South Americans, 7%; Other Spanish Speaking, 13%.² The major identifiable groups - Mexican Americans, Puerto Ricans, and Cubans - live for the main part, in different parts of the country. 60% of all Spanish Speaking (86% of the Mexican Americans) live in Texas, Colorado, New Mexico, California, and Arizona.³ 56% of the Puerto Ricans⁴ live in New York City. The remainder of the Puerto

1

Data comparing Spanish Speaking with Total Population and Whites, Blacks derive from 1970 Census of Population, U.S. Summary, General Social and Economic Data. However, for comparative data among the Spanish sub-groups the Special Reports, Series P-20 #213, February 1971; P-20 #224, Oct. 1971; and P-20, #238, July, 1972 have been utilized. In all cases, the most recent data available is utilized.

2

1970 U.S. Census of Population U.S. Summary General Social and Economic Data. Since this is the generally accepted total for the Spanish Speaking in the U.S., this figure is reported. The data for the sub-groups derive from P-20 #238 - July, 1972. Table 1. Total exceeds 100% due to rounding.

3

Series P-20, #213, Feb. 1971, Table 2. U.S. Census.

4

PCX(1)-C34 New York General Social and Economic Characteristics. 1970 Census of Population. There are 811,843 Puerto Ricans in New York City. Series P-20, #224. Total Puerto Rican Population in U.S., March, 1971, the closest comparable data, was 1,450,000.

Ricans live largely in the Northeast and Mid-Atlantic states. Cubans, for the most part, live in Florida.

Of all Spanish speaking population; 61% were born in the United States; 12% were born in Puerto Rico; and 27% were born in a foreign country. The percentage born outside the United States varies from 17% of Mexican Americans; 56% of Puerto Ricans; 64% of the Central and South American; to 82% of the Cubans.¹

Although there are marked similarities among the groups based on language and cultural identity, there are dissimilarities based on income, family cohesion, employment, and degree of integration with other groups in American society. The "Other Spanish" are most widely scattered throughout the United States and have the lowest ratio of marriage with other persons of Spanish Origin - only 39%. Intermarriages among the groups are rare (only 5%),² in large measure a product of the geographic distance that separates the groups. However, a strong sense of ethnic and cultural identity is continued on the basis of high level of marriage within each group. For example, 83% of all Mexican American married men married Mexican American women. The percentage runs as high or higher for Puerto Ricans and Cubans.³

¹Series P-20 #213, Table 2.

²Series P-20 #213, p.7 U.S. Census 1970

³Series P-20 #213, Table 4, U.S. Census 1970.

With the high percentage of Spanish Speaking men marrying Spanish Speaking women, the 50% who report speaking Spanish currently in the home is not surprising:

Language Usually Spoken in the Home
by Origin: 1969¹

Spanish Origin	50%
Mexican American	47%
Puerto Rican	72%
Cuban	87%
Central and S.Amer.	54%
Other Spanish	16%

47% of all children under 14; 49% of all children 14 - 15, and 50% of all 16 - 24 year-olds currently speak Spanish in the home.² This indicates a need for continuing bilingual programs throughout elementary and high school rather than just at the K-3 level, where the bilingual program presently focuses its attention.

a. Age

The Spanish Speaking are an exceptionally young population. The median age of the total U.S. population is 28 years, but is 20 years for those of Spanish origin.³ Puerto Ricans are the youngest with a median

¹

Series P-20, #213 Table 10, U.S. Census

²

Series P-20, #213, Table 3, U.S. Census

³

Series P-20, #213, Table 11, U.S. Census

age of 18, Mexican Americans next with a median age of 19. Median age of Cubans is 34 years. There is a marked differential in age between persons of Spanish Origin as a whole, (20 years) and those who reported Spanish as their Mother Tongue, 23 years for native¹ born and 35 for foreign born.

With so great a concentration of young people in the Spanish Speaking population, the greatest need for services among the Spanish Speaking is for maternal and child services, early childhood development, nutrition during pre and post natal care, pre-school and educational services, and for training Spanish Speaking staff to provide these services.

b. Education

Percent of the Population 25 Years Old and Over Who Had Completed Less Than 5 Years of School or 4 Years of High School or More, by Ethnic Origin: March 1972²

Years of school completed and age	Total population	Spanish origin		
		Total ¹	Mexican	Puerto Rican
COMPLETED LESS THAN 5 YEARS OF SCHOOL				
Total, 25 years old and over.....	4.6	19.2	26.7	20.2
25 to 29 years old.....	0.8	7.5	7.3	5.8
30 to 34 years old.....	1.4	6.4	12.6	8.7
35 to 44 years old.....	2.8	15.9	21.0	19.9
45 to 54 years old.....	3.4	25.1	33.1	29.9
55 to 64 years old.....	5.6	30.8	47.9	(B)
65 years old and over.....	12.2	51.3	74.8	(B)
COMPLETED 4 YEARS OF HIGH SCHOOL OR MORE				
Total, 25 years old and over.....	58.2	33.0	25.8	22.7
25 to 29 years old.....	79.8	47.6	42.9	30.9
30 to 34 years old.....	73.9	42.7	40.1	22.6
35 to 44 years old.....	66.8	36.2	28.0	27.2
45 to 54 years old.....	59.8	24.9	14.2	21.3
55 to 64 years old.....	46.7	20.6	8.8	(B)
65 years old and over.....	32.0	12.1	0.6	(B)

B Base less than 75,000.

¹Includes other persons of Spanish origin, not shown separately.

1 Series P 20, #213, Table 7, U.S. Census
2 Series P 20, #224, Table 4, U.S. Census

With the younger groups, there is a marked drop in the percent who remain in school less than five years, and a rise in the percent of those who complete high school. Although these figures indicate an improving educational picture for the Spanish Speaking, the continued lag between the Spanish Speaking and the total U.S. population indicates the failure of schools to serve effectively their Spanish Speaking population.

A number of individual reports indicate that major problems still exist in school retention. In Texas, 89% of the Spanish Speaking students drop out before finishing high school. In some high schools in California, 50% of the Mexican Americans drop out between the 10th and 11th grades.¹ New York City schools report a 52% drop-out rate for Puerto Ricans.² In Hoboken, N.J., the drop-out rate of Puerto Rican children is even more precipitous, from 56% of all elementary school children to 34% of all students in high school.³

1 Mexican American Consultant Report.

2 Puerto Rican Consultant Report.

3 Directory of Public Elementary and Secondary Schools: Enrollment and Staff by Racial/Ethnic Group, 1970. DHEW

Of all Spanish Speaking 18 - 24 years of age who graduate from High School, only 2.9% graduate from college; whereas 68% of White 18 - 24 graduate from High School, and 6.7% graduate from college.¹ (It is noted that a significant number of students graduate from college after they reach 24 years of age, particularly among those who have to work while they are attending school, which may account for the lower percent of Spanish Speaking graduating from college.)

The serious absence of professional Spanish Speaking staff to serve the Spanish population can only be affected by expanding the number of Spanish Speaking who both attend and graduate from college.

c. Employment

Mexican American men have the highest labor participation rate, in part a product of their lower school attendance, but also indicating that the group begins working at an early age to contribute to family needs. The labor participation rate for Puerto Ricans is excessively low, largely because of limited opportunities, and a high unemployment rate - 9%.

1

General Social and Economic Characteristics, U.S. Summary, U.S. Census Population 1970 Table 88.

Labor Force Participation Rate of Males 16 - 64 Years of Age
And Unemployment Rate¹

	% Males In Labor Force	% Males Unemployed
Total Population	86.0%	6.0%
Spanish Origin	85.0	7.4
Mexican American	86.5	7.9
Puerto Rican	76.6	8.8

The unemployment rate for Puerto Rican males is precipitously high. The problems caused by the high Puerto Rican unemployment rate is also compounded by the low status of the jobs they obtain when they are working.

Forty-four per cent of Whites are employed in White Collar jobs compared to only 18% of Mexican Americans. Among high level White Collar jobs there are 3 times as many Whites as Mexican Americans. Among service workers, 18% of Puerto Rican men are so employed compared to 8% White.

¹Series P-20, #238, Tables 5 and 6

Table 9. Employed Men 16 Year Old and Over, by Major Occupation Group and Ethnic Origin: March 1971 ¹

(Numbers in thousands. Civilian noninstitutional population)

Occupation	Total population			Spanish origin		
	All races ¹	White ²	Negro and other races	Total ³	Mexican	Puerto Rican
Total employed.....	47,979	43,307	4,671	1,826	997	232
Percent.....	100.0	100.0	100.0	100.0	100.0	100.0
White-collar workers.....	41.7	43.9	22.0	23.2	18.2	19.8
Professional and technical.....	13.8	14.5	7.2	7.2	4.5	6.2
Mgrs., Admin., exc. farm.....	15.1	16.1	5.2	6.4	5.4	4.8
Sales workers.....	6.1	6.5	1.8	2.7	2.2	3.0
Clerical workers.....	6.8	6.7	7.7	6.9	6.2	5.8
Blue-collar workers.....	45.1	43.7	57.4	57.9	62.5	59.9
Craftsmen and kindred.....	19.5	20.2	13.1	18.2	19.7	13.3
Operatives, including transportation.....	18.4	17.6	26.7	27.6	27.7	33.4
Laborers, exc. farm.....	7.1	5.9	17.7	12.1	15.0	13.5
Farm workers.....	4.9	4.9	4.9	5.3	8.3 ²	1.7
Farmers and farm managers.....	3.2	3.4	1.3	0.3	0.1	-
Farm laborers and foremen.....	1.7	1.5	3.6	5.0	8.2	1.7
Service workers.....	8.3	7.5	15.7	13.6	11.1	18.2

- Represents zero or rounds to zero.

¹Includes persons of "other races," not shown separately.

²Includes almost all persons reporting Spanish origin. About 97 percent of persons of Spanish origin, about 99 percent of persons of Mexican origin, and 98 percent of persons of Puerto Rican origin were classified white in this survey.

³Includes persons of Central or South American, Cuban, and other Spanish origin, not shown separately.

¹Series P-20 #224, Table 9

²Series P-20 #224, % Mexican American Farmworkers, Series P-20 #238, 1972 - 8.3% - #213, 8.7%

Spanish women are only recently beginning to move into the labor force and there is still a marked difference between their employment patterns and that of whites and blacks. For the total population, 50%¹ of the women 16 - 64 are employed² whereas 40% of Spanish Origin, 39% of Mexican American and 26% of Puerto Rican women are so employed. Part of the cause of low labor participation rate for Puerto Rican women is, no doubt, their excessively high unemployment rates (17%).³

More recently, Spanish Speaking women with young children have begun to move into the labor force, indicating the need for pre-school and after school care of Spanish Speaking children. The same percent of Spanish Speaking women (28%) with children under 6 are in the labor force as the percent of all women; and the percent of Spanish Speaking women with children 6 - 17 in the labor force is only 5% less (44%) than for all women (49%).⁴

Data on the occupational classifications for women indicate a great disparity between the level of employment for the total population and Spanish Origin women. 61% of women in the total population are employed in White Collar jobs, but only 41% of Spanish Origin, 38% of Mexican American and 39% of Puerto Rican women are found in this category. On the other hand 16% of all women are employed in Blue Collar jobs, as opposed to 54% of Puerto Rican women.⁴

¹Series P-20, #238, Table 5

²The closest comparable rate for Black women, from 1970 Census for all women 16 and over is 53%.

³Series P-20, #238, Table 6

⁴General Social and Economic Characteristics, U.S. Summary 1970 Census of Population

22% of all women are employed in Service Occupation, as opposed to 32% of Mexican-American women. The tremendous change in the lives of Mexican-American women is reflected in the fact that only 1.2% of those employed are employed in farmwork.¹

The result of the lower level of employment for both men and women is reflected in the lower income levels of the Spanish Speaking.

d. Income

Median family income for the total population in 1972 was \$10,285, for Mexican Americans it was \$7,486, for Puerto Ricans it was \$6,185, for Cubans \$9,371. The income level of all Spanish Origin families is 73% of Whites. Among Spanish Origin persons, the most deprived are the Puerto Ricans whose income is only 60% of Whites.² The problem is even more dramatic when per capita income is examined which reflects the larger Spanish Speaking family, where per capita income of all Spanish Speaking is only 62% of Whites (11% less than percent of family income).³ Per capita income for the nation as a whole is \$2,939. However, per capita income for Puerto Ricans is \$1,628 and \$1,701⁵ for Mexican Americans.

Twenty-six per cent of all Spanish Origin families are in poverty. Poverty among the Mexican Americans is 2.3 times higher than for the total population, 2.6 times higher for Puerto Ricans,⁴ indicating the need for a

1 The latest data on Spanish Women by sub-group derives from P-20 #213 - 1969. The only data for the total population derives from the 1970 Census U.S. Summary taken five months later.

2 Series P-20 #238 - Table 9.

3 U.S. Census 1970 U.S. Summary

4 Series P-20 #238 - Table 10.

total range of services to assist Spanish Speaking families to raise their employment and income levels.

6. Longevity and Health

Of the total population, 9.7% are 65 years or over, but only 4.1% of the Spanish Speaking are over 65;¹ (3.2% of the Mexican Americans and 2.0% of the Puerto Ricans.²)

Since only 17% of the Mexican Americans and 15% of the Other Spanish Speaking were born abroad, and since these two groups represent 72% of all Spanish Speaking, the extremely low percentage of Spanish Speaking over 65 cannot be dismissed as being totally a product of mobility patterns caused by the lower number of older persons migrating into the U.S.³ The low percentage of those 65 and over may be in part a product of the high birth rate among Spanish Speaking, but that too will not account for the extremely low percentage of Spanish Speaking 65 and over. Only continuing health problems and an early death rate will account for the few Spanish Speaking 65 and over in the population.

Vital statistics on the Spanish Speaking are extremely difficult to obtain or extrapolate. United States health statistics (and almost all state and local data) report Spanish Speaking as White and do not keep separate data for the Spanish Speaking. However, the State of Colorado did undertake

¹1970 Census of Population, U.S. Summary General Social and Economic Characteristics.

²P-20 #238, Table 2

³P-20 #213, Table 2

a special study on the Spanish Speaking in 1967 which corroborates the fact that the life expectancy for Spanish Speaking is markedly below that of the general population - 56.7 years for the Spanish Speaking and 67.5 for the general population.¹

f. Social Security

Of the small proportion of Spanish Speaking 65 and over (4.1%), an even smaller percentage receive Social Security. Although 76% of all Whites over 65 receive Social Security; only 65% of the Blacks, and 60% of the Spanish Speaking over 65 receive Social Security.²

Twenty-three per cent of all persons in poverty are 65 and over. Of this group, 77% receive Social Security. 5.6% of all Spanish Speaking in poverty are 65 and over and of that group only 58% receive Social Security.² With the recent rise in Social Security payments, many of the old persons on Social Security will now have an income that will permit them to provide for basic necessities. However, 42% of Spanish Speaking old people in poverty but not on Social Security, the problem of basic survival remains. In the five Southwestern states, the average monthly payment under Old Age Assistance is \$62 per month, insufficient to support even a primitive life style. This is clearly a critical problem for the Spanish

1 Mexican American Consultant's Report.

2 1970 U.S. Census - U.S. Summary General Social & Economic Characteristics.

Speaking older person who either does not qualify for Social Security or, due to language and communication problems, does not know he is qualified.

With the low percentage of Spanish Speaking who reach 65 years of age and the even lower percentage of Spanish Speaking receiving Social Security benefits, the increased taxes being paid by Spanish Speaking young and middle-aged are highly discriminatory.

9. Health Data

The incidence of health problems, particularly those related to low socio-economic status, is a major problem for the Spanish Speaking, but the absence of health data specifically for the Spanish Speaking is almost total.

Certainly one of the causes of poor health among the Spanish Speaking is the excessively low numbers of Spanish Speaking health professionals in the United States and the lack of bilingual services available to the Spanish Speaking. Only 0.5% of all doctors in the United States are estimated to be Spanish Speaking.

A recent report of the School of Public Health at the University of California at Los Angeles indicates that "There is a complete lack of data on health services available to Mexican Americans and the degree to which

these services are utilized by members of the group."¹

Census does not include data on health and many health programs do not report beneficiary data. Data on Medicare and incidence of disease will have to be accumulated for those cities and counties having a high ratio of Spanish Speaking population. This data will then be compared to health data for the general population in order to develop some indices of disease for the Spanish Speaking. This will be done in Phase II of the study.

¹

Mexican American Consultant's Report.

II. B. Spanish Speaking

1. Mexican Americans¹

There are approximately 5,254,000 Mexican-Americans in the United States, representing 57% of the Spanish Speaking and 2.6% of the country's total population. It is a young population, with a median age of 18.6 years. Mexican-American families are large, the largest average family size of any group in the country, a significant factor in the young median age. Another significant factor is that the average life expectancy is 57 years compared to 67 years for the country as a whole. The per capita income of the Mexican-American group is \$1,701 which is below national figures.² 47% of the Mexican-American families speak Spanish at home.

The data indicate serious poverty among the Mexican Americans in the Southwest. While comprising only 16% of the total population, they constitute 32% of all low income persons. They are more poorly educated, with 20% of those over 25 having had less than 6 years schooling, five times the comparable figure for Whites. The very low percentage of the Mexican American population over 65 (4%) raises the question of a high incidence of serious health problems. The unemployment rate is 1.7 times higher than the national average for men and women.

¹Most of the following data on Mexican Americans comes from state-by-state analyses of the five southwestern states - Texas, New Mexico, Arizona, Colorado, and California - which contain 86% of the United States Mexican-American population. Unless otherwise stated, statistics are from the consultant's Phase I Final Report.

²Population Characteristics; Series P-20 No 238, July 1972, Tables 3 and 9.

Due to negative experiences, many Mexican-Americans live with a constant distrust of government officials. No other group of American citizens are called upon as often to produce proof of citizenship in their own country. Newly immigrated Mexican Americans fear indiscriminate deportation and are, therefore, reluctant to utilize government agencies.

Many of the services offered Mexican Americans are not responsive to their poverty conditions or their cultural situation. A substantially lower percentage of Mexican Americans over 65 receive Social Security benefits than is found in the general population over 65. Also 29% of the Mexican-American population are of low income status.

Mexican Americans are underserved by public assistance programs. In Texas, for example, of the 31% of Mexican-American families below the poverty level, only 8% receive public assistance, as opposed to 12% of the White families below the poverty level with 6% receiving public assistance. The Office of Civil Rights (OCR), DHEW, found in Sonoma County, California, that while Mexican Americans constitute 22% of the poverty population, they constitute only 6% of the public assistance caseload.

In East Los Angeles, the vast Mexican-American community is served by the Los Angeles General Hospital which is difficult to reach - over an hour away by public transportation for some - and lacks adequate bilingual staff (only 6 out of 400 nurses are bilingual). Yet funds to build a more centrally located facility, planned in a manner which responds to

bicultural needs, have not been made available through Hill-Burton funds.

For the most part the services received by Mexican Americans are not responsive to the degree and nature of their needs. The U.S. Commission on Civil Rights estimates that, "out of well over a million Mexican Americans in school districts with 10% or more Mexican American enrollment, only 29,000 Mexican American pupils were enrolled in bilingual education classes; although 47% of all Mexican American children under 14 currently speak Spanish in their homes". There is also a shortage of Mexican American teachers to staff bilingual programs. In the fourteen selected cities and rural areas having a large Mexican American population included in the Phase I study, Mexican Americans constituted 32% of the elementary school student population, but only 3% of the teachers were Mexican American. At the high school level, 25% of the students, but only 2% of the high school teachers were Mexican American.

In its Sonoma County investigation report, OCR wrote:

"Interviews with clients and caseworkers indicate that the absence of bilingual telephone operators has resulted in significantly greater burdens on Spanish Speaking potential clients in terms of greater time delays, more required visits to the Department's office and, as a result, the additional burdens of child care, and transportation time and expense. Moreover, this breakdown of communication regarding general eligibility for benefits and enrollment procedures has led to a failure by Spanish Speaking clients to enroll for benefits to which they are entitled by law."

These kinds of service deficiencies might explain the low rate of Mexican American participation in welfare and health programs throughout the Southwest.

In addition, Mexican Americans are beset by both state and Federal regulations requiring lengthy periods of citizenship or residency to be eligible for basic services. For example, to be eligible for OAA in Texas, one must have been a citizen for 25 years; in Arizona, for 15 years. Supplementary Medical Insurance (SMI) under Medicare requires residency for at least five years prior to the date of one's 65th birthday in order to qualify. Many elderly Mexican American aliens do not apply because they do not realize they can qualify. Even when they are aware of the services, many Mexican Americans indicate a distrust and non-reliance on public service programs available for their use. Therefore, the services are used less and the Mexican Americans continue to have major health, welfare, and service problems.

An added dimension to the plight of the Mexican American is the migrant farmworker. In following the agricultural belt, the Mexican American experiences unique health and education problems. A farm worker may travel up the west coast of California to Washington and back again, or start in Texas and travel to Michigan in order to plant and then harvest crops. This type of situation severely inhibits regular medical care and all but eliminates education of the young.

The Mexican American consultant contacted a variety of community agencies serving the Mexican Americans in the Southwest. A variety of problems in the delivery of DHEW services were identified by these community groups:

a. Health

- 1) One survey reported that 95% of those interviewed considered health to be their primary problem.
- 2) There are not enough health services available, in both urban and rural areas, and those that are available are too costly. Lack of funds is a major barrier to Mexican Americans receiving adequate health services.
- 3) There is a need for comprehensive family health centers to deal with the total health problem of the family as a unit, as opposed to separate clinics for youth, elderly, etc.
- 4) Health Maintenance Organizations, the major new health thrust of DHEW, are viewed as discriminating against poor Mexican Americans. HMOs have been competing for clients who can pay the monthly fees or have insurance coverage, thereby ignoring the others most in need of health services.
- 5) Newly immigrated Mexicans have the most difficulty seeking health services since they fear embarrassment, discrimination and deportation. Illegal aliens particularly fear detection and deportation and therefore fear government-related services. Also many Mexican Americans born in Mexico miss the folk medicine they have been accustomed to.
- 6) There are not enough qualified Mexican American medical personnel. There is a need for a major increase in training funds and scholarships earmarked for Mexican Americans.

7) Medical training programs earmarked for Mexican Americans are not being fully utilized because few have the funds required to take advantage of them. Related problems here are lack of educational preparation for such training and the necessity of severing family ties in order to live near such programs.

b. Education

- 1) In many cases, the school districts are reluctant to use local funds for such innovative programs as bilingual education and will not accept Federal funds because of the "commitments" they have to make to obtain them. Tucson, for example, with a 28% Mexican American elementary school population turned down nearly \$70,000 in ESEA money for bilingual education. The Mexican American population has no recourse in such a situation to protect the interest of its children.
- 2) There is no ethnic relevance of school curricula to the ethnic population. Contributory significance of Spanish-Mexican-Indian cultures to Southwest development is seldom given appropriate recognition.
- 3) There is a need for bilingual staff - including teachers, counselors, and administrators - in the school systems who can relate culturally to their students.
- 4) A Title VII program in Crystal City, Texas, operated by a Mexican American superintendent and a Mexican American school board with bilingual teachers, as well as teacher aides, could serve as a model for replication. Few similar favorable reports on such programs were identified.

c. Overall Service Delivery

- 1) Mexican Americans are rarely involved in planning or monitoring programs designed to serve their community.
- 2) Transportation to facilities is a major on-going problem. Facilities are poorly placed for the Mexican American community and public transportation is inadequate to serve the barrios. More DHEW funded services should be decentralized into the barrios.
- 3) There is an absence of bilingual personnel at all levels, with the exception of the para-professional community worker at the intake level.

d. Highlights

Mexican Americans are characterized by large families and a young population, indicating a need for heavy emphasis on infant, child, and educational services; the low life expectancy indicates the need for better health care; 60% speak Spanish at home, indicating the need for bilingual staff in agencies serving Mexican Americans; distrust of Federal agencies because of harassment and fear of deportation and culturally insensitive programming, indicates the need for a program planning process which involves the Mexican American community and which endeavors to respond to the cultural values and unique life situation of Mexican Americans.

II. B. Spanish Speaking

3. Puerto Ricans¹

There are approximately 1,450,000 Puerto Ricans in the continental United States. 811,843, or 56%, live in New York City. Over half are recent arrivals from Puerto Rico, most speaking little or no English.

They are the most severely disadvantaged Spanish Speaking group and have little economic or political leverage. The median family income is \$6,185. Compared to a national figure of \$10,285 their per capita income is \$1,625-the lowest of any Spanish Speaking group. 32% of all Puerto Ricans live in poverty. 29% of the households are headed by females, the highest for any group in the country.² Families tend to be large, with many young children. Over 50% of all Puerto Ricans have the lowest percentage of persons over 65 of any group in the country, 2% as against a national rate of 9.5%.

The unemployment rate for males is 1.8 times the national average, one of the highest for any group and the highest for any group in New York City where 56% of the Puerto Ricans in the United States live. The unemployment rate for male Puerto Rican 16-25 year olds is 25%, almost twice the national average, indicating a critical need for vocational education and other manpower services.

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1. Data not elsewhere cited derive from the ethnic consultants report. All data discrepancies between Puerto Ricans and Spanish Speaking have been eliminated to align Puerto Rican data with data from Spanish Speaking Report derived from U.S. Census. (See footnotes in Spanish Speaking overview.)
 2. Data quoted from P-20 #238. Negro female heads of households is 27.4% according to 1970 Census U.S. Summary.

The labor force participation rate for Puerto Rican females is 26% in 1972, the lowest for any group, but it is slowly rising toward the national average of 41.4% for females 16 years and over.¹ This fact, coupled with the highest number of female heads of households and the largest number of young children, indicates a need for increased day care services to Puerto Ricans to permit more Puerto Rican women who so desire to enter the labor market.

Puerto Ricans have a low level of educational achievement. By the 6th grade the Puerto Rican student is 3 years behind the average White and the dropout rate is extremely high. Over 23% of those over 25 have less than a 6th grade education. The seriousness of this situation is compounded because many Federal training programs require at least a sixth grade achievement level for entry, and training curricula are often designed for a 6th grade achievement level or above. In this situation, Puerto Ricans find themselves ineligible for many programs and programs designed for their educational level are seldom available from any source. It is estimated that about 30% of the Puerto Rican student population is non-English speaking. 40% of the adults cannot read English and over 25% of those are illiterate in Spanish as well, indicating a need for major expansion of bilingual education resources for Puerto Ricans. Yet, in New York City where 26% of the school population is Puerto Rican, only 1% of the teachers are Puerto Rican.² Or

1 1970 U.S. Census, U.S. Summary

2 OCR/DHEW 1970 Directory of Public Elementary and Secondary Schools.

the 31 Puerto Rican education Title I projects in New York City, only 14 are headed by a Puerto Rican director.

Similarly, in most cases, health facilities are not responsive to the needs of the Puerto Rican community. The Massachusetts Advisory Committee to the U.S. Commission on Civil Rights conducted a study of the three hospitals in Springfield, Massachusetts. Though all three hospitals had received substantial amounts of money from the Hill-Burton Program, the study found inadequate services for Puerto Ricans. It found that the hospitals were not conveniently located to the Puerto Rican community and the transportation facilities to the hospital were not adequate. The hospitals made no outreach effort to the Puerto Rican community. There were only 21 Puerto Rican employed above the janitor/orderly level.

In an effort to identify the problems of Puerto Ricans as perceived by the Puerto Ricans, the Puerto Rican Consultant contacted many Puerto Rican community agencies in the Northeast and Middle Atlantic areas. The issues identified by these Puerto Rican Agencies included:

a. Health

- 1) Hospitals in Boston ignore the Puerto Rican community, and do not adjust their services to the needs of the Puerto Rican community.
- 2) Language barriers limit the utilization of health services and facilities by Puerto Ricans. There is not enough bilingual staff and virtually no Puerto Rican staff at most hospitals and health centers.

3) Inadequate health facilities exist to deal with chronic recurring tropical diseases that many Puerto Ricans are afflicted with.

4) Hospitals are inconveniently located to concentrations of Puerto Ricans. Public transportation is a major barrier to the use of health facilities since it is inconvenient, time-consuming and expensive.

5) There is a far greater demand for pre- and post-natal care than is available.

6. There is no health care in the schools for Puerto Rican children, although Medicaid should be providing such service.

b. Education

1) Bilingual programs are not available to most Spanish Speaking Puerto Rican children. Many of the programs that are available are inadequate, lacking bilingual staff and appropriate curriculum.

2) Inadequate concern is expressed by elementary and secondary school staffs for problems peculiar to Puerto Rican students.

c. Welfare

1) The welfare allocations are inadequate for the needs of large Puerto Rican families;

2) Puerto Ricans do not receive their due from welfare since many Puerto Ricans are not aware of services and special allocations to which they are entitled, and thus do not ask for them.

- 3) There are almost no Puerto Rican staff employed by the Welfare agency.
- 4) There is a need for vastly expanded Day Care Centers.

d. Highlights

Thirty-two per cent of all Puerto Ricans are living in poverty. 29% of the households are headed by females, indicating a major need for day care facilities. 50% of all Puerto Ricans are recent arrivals and 30% of the students are non-English speaking. 40% of all Puerto Ricans are illiterate in English, indicating the need for intensive bilingual services and programs for adults as well as children. Young Puerto Rican males have a low level of educational achievement and a very high unemployment rate, pointing to the need for vocational education and other manpower programs. There is a very low percentage of Puerto Rican professionals in health, welfare, and education agencies and programs - indicating a need for intensive training programs to develop the staff necessary to enable service programs to deliver bilingual/bicultural services.

II. C. Asian Americans*

1. Overview

There are approximately 1.5 million Asian Americans in the United States. The five largest Asian American subgroups are the Japanese-Americans (591,000), Chinese-Americans (435,000), Filipino-Americans (343,000), Samoan-Americans (62,000), and Korean-Americans (50,000).¹ Each of these subgroups has a distinct cultural heritage, history, and language, has had different time sequences for immigration, and differing patterns of engagement with Western culture. As a result, each has differing needs or level of need for HEW services. All five subgroups do, however, share certain common problems and a common neglect from public service agencies. The problems common to all five groups are traced in this section to provide an overview. The specific and unique nature of the five major subgroups are then analyzed individually.

One of the most consistent and significant findings of the Phase I study on Asian Americans is that there is almost no hard national data or definitive information available

* Any data or other information contained in this section not otherwise cited comes from the Ethnic Consultant Reports.

1. 1970 U.S. Census; however, the 62,000 Samoan population figure comes from the "Summary of Asian-American Problems" issued by the Office of Asian American Affairs, OSC, DHEW. In the Samoan section of this chapter, the Samoan population in the U.S. is cited as 48,000. The source of that figure is a study entitled "Samoan Community Report" which is included in the Final Evaluation Report, Demonstration Project for Asian Americans, July 1971 - February 1972 submitted by the Asian American Social Workers, Executive Task Force. The wide gap in the population figures on Samoans in the U.S. - from two reliable and knowledgeable sources - points up dramatically the need for a detailed study of the Samoans and other Asian American subgroups through analysis of the forthcoming Special Census Report on Asian Americans in Phase II of the Ethnic Minority Study.

from which to determine either the extent of their need for HEW services or the extent to which HEW is providing services to them. What information and data that are available usually pertain to isolated communities and programs and are not sufficient to draw definitive conclusions either on the Asian American subgroups or on the group as a whole. Phase I found that Asian Americans tend to be ignored in most studies of minority or poverty problems in this country. No fully comprehensive studies on the population, socioeconomic, educational, or health characteristics of Asian Americans as a group or of each of the subgroups on a national or regional level could be found. Most government reports group them in the statistical category labeled "Other" where, mixed in with other unidentifiable groups, they remain anonymous and invisible. Beneficiary data gathered by the various agencies with DHEW do not currently provide a breakdown for Asian Americans. More often than not they are ignored by DHEW planners. For example, despite the fact that there are an estimated 63,000¹ Asian American students in need of bilingual programs, the statement of program goals, objectives and accomplishments prepared by the Title VII staff in response to this study did not even mention Asian Americans as a target group. Most of the literature and studies dealing with "minorities" or "ethnic minorities," including evaluation and planning contracts let by DHEW on behalf of the "ethnic minorities", do not acknowledge the existence of Asian Americans, de-

1. Since no precise figure exists, a rough estimate was made based on the number of Asian immigrants of school age that have immigrated within the last five years.

fining the group as consisting of just the Spanish Speaking and Indians and sometimes Blacks. Asian Americans are truly invisible Americans.

When Asian Americans are recognized by Federal, State or local governments as a distinct ethnic group, the recognition rarely extends to the diversity that exists among the Asian American subgroups. Not only does each subgroup speak a different language, but in some cases several different dialects as well may be spoken within a given subgroup (Mandarin, Cantonese, Toishanese for the Chinese) (Tagalog, Ilocano and others for the Filipino). Filipinos are often indiscriminately lumped with Mexican Americans and Latinos, and Samoans have oftentimes been considered Black, although frequently neither group receives services that accrue to the groups with which they are erroneously identified since they are not likely to seek out service programs which cater to other ethnic groups (i.e., Mexican Americans).

The limited glimpse which the Phase I study was able to get of Asian Americans, primarily information culled from studies conducted in California in 1965, indicated that Asian Americans are a minority group with serious poverty, language, and other problems, and that their needs have not been adequately recognized, let alone served by DHEW programs:

"The large numbers of Asian Americans who were outside of the United States have unique cultural patterns and languages that serve as their means for social interaction and communication. Even many of those born in this country still retain their particular cultural patterns and language.

English, to them, is a foreign language, and the "mainstream" of American life is a foreign culture to them. While their native cultures provided ways and means to maintain the common good, American society has not allowed the channels and resources in the traditional ways."¹

Yet this country's system for delivering health, educational, and social services has often either ignored Asian Americans or has not provided services in a culturally relevant manner, the latter affecting the ultimate impact of services. With the old and traditional systems for meeting their needs gone or disrupted, a new one yet to be devised on any significant scale, in areas of service that often touch their very physical and cultural survival.

A large percentage of Asian Americans eligible for services or payments through various formula grant programs (i.e., Social Security, Public Assistance, Old Age Assistance Medicare, Medicaid, Public Health Services, etc.) are non-English speaking or have only limited ability with English. Many of those eligible have never applied for payments or services because of the lack of bilingual information dissemination and outreach. Effective service delivery to these individuals would require that informational material

1. A summary of Asian American Problems, Office of Asian-American Affairs, OSC, DHEW. p.3

be translated into Chinese, Tagalog, Japanese, Korean and Samoan languages, and that outreach efforts be conducted with bilingual/bicultural staff where there are large concentrations of non-English speaking Asian Americans.

The limited amount of information found by the Ethnic Consultants did indicate, however, that the two elements of the Asian American population most in need and most underserved are the Asian American elderly and the recently arrived Asian immigrants.

a. Elderly Asian Americans

For the hundred year period ending with the Depression of the 1930's, America experienced the most rapid economic and industrial growth in its history. During that same period hundreds of thousands of Asians were imported to this country to provide the backbreaking labor to make this growth possible. Different subgroups came at different times. First the Chinese, until they were barred by the 1882 Chinese Exclusion Act. Then the Japanese until the "Gentleman's Agreement", forced on Japan in 1907 by the United States, coupled with the 1924 Alien Exclusion¹ Act, halted the immigration of further Japanese workers. They in turn were replaced with Filipino laborers until their immigration was halted by the combined effects of the 1924 U.S. Immigration Quota Laws and placing of the Philippines in Commonwealth status in 1935. Members of some or all of the Asian American subgroups built the

1. The Japanese American Experience, a study by the Japanese American Citizens' League.

railroads, worked the mines, and tended the crops on the West Coast farms. Though at different times and in different ways, each group was rewarded for its labors by waves of anti-Asian racism and persecution. They were persecuted as threats to the American working man. They were denied membership in unions or certain occupations. They were prohibited from owning land, securing business licenses, or engaging in other activities which would have enabled them to develop some economic security. Eventually, the anti-Asian agitation drove them out of the industries they helped to build and into low paying menial jobs that were not competitive with White labor. Thus, Asian Americans were penalized because they were very industrious and many were later branded as lazy and shiftless because of their poverty which was more than not the result of discriminatory laws and practices.

Most of the laborers came to this country by themselves, with the expectation of bringing over their families once they got settled and saved some money. But, because they were not allowed to become citizens, they were unable to get their families past the immigration barriers. Yet at the same time, the Western states were passing anti-miscegenation laws directed at the Asian American laborers, so they could not marry Caucasians. As a result, many have grown old without wives and families, without economic resources and usually without any retirement benefits. There are now thousands of single elderly Asian men, hidden away in one room apartments in cities throughout the West

Coast - without families to take care of them. Most of them have severely limited English ability, with major problems of cultural adjustment, and having been excluded, many have made few cultural adjustments because they are now too old either to want to or to be able to. They have a desperate need for the basic life sustaining services of health, food and welfare.

Yet, as will be discussed throughout the Program and Issue sections of this report, they have not received more than token attention from DHEW agencies. SRS has funded almost no programs specifically designed for the Asian American elderly. Many Asian American elderly who entered the country under false birth certificates but who have since cleared their residency with the Immigration and Naturalization Service have been disqualified and/or penalized from receiving Social Security because of DHEW's method of evaluating eligibility which often refuse to accept Immigration and Naturalization Service records for proof of date of birth. Yet there seem to be no nursing homes and a general lack of comprehensive and home care programs that address the specific needs of the Asian American elderly. No training programs could be found that are specifically designed to train bilingual/bicultural personnel¹ to work with Asian American elderly.

1. A Summary of Asian American Problems, OAAA, OSC, DHEW p. 7.

b. Recently Arrived Immigrants

In 1965 the immigration laws were liberalized, permitting sizeable numbers of Asians to immigrate to this country for the first time since the enactment of the various Exclusion and Quota laws. The number immigrating have increased yearly since then. In 1972 Asian immigration totaled 70,348. Filipinos represented the largest number (29,376), followed by Koreans (18,876), Chinese (17,339), and Japanese (4,757).¹ The characteristics of the immigrants differ from country to country. In 1970 about one-third of the Filipino immigrants were professional or technical workers and their families. For the Japanese only about 10% were in this category but almost half were wives and children of American citizens.² Almost all, in whatever category, experience the language and cultural adjustment problems faced by recent immigrants; the problems of poverty, unemployment, underachievement in school, health problems, and the cultural shock from entering a different world. Underemployment is a particularly severe problem. Many of the professional and technical workers are unable to use their skills because of language and licensing barriers and employer stereotyping of Asian Americans, and end up in menial jobs which waste their talents and frustrate their opportunity for self-fulfillment. Since a full 20% of the Asian-American population

1. United States Immigration and Naturalization Service phone call on February 27, 1973

2. 1970 Annual Report Immigration and Naturalization Service pp 40-48

has been in this country less than seven years,¹ there are many Asian Americans who need a full range of services to help them effect a satisfactory transition to American life consistent with their talents and aspirations. These services are apparently not being provided. In San Francisco, the little effort made in this direction has been severely weakened by a school desegregation pattern imposed by the San Francisco schools which has increased the drop-out rate, and has diffused the services that were beginning to have a slight impact on young Chinese immigrants.

c. Poverty

Visits to Asian American communities by the Ethnic consultants, and reports they received from Asian American community groups seem to indicate varying levels of poverty in the various Asian American communities and the social ill associated with it. There are signs of serious juvenile problems in Japanese and Chinese and also Korean communities; severe unemployment in Filipino and Samoan communities; substandard housing in most Chinatowns and Samoan areas. But there is almost no definitive data from which to fully determine or derive the full nature or magnitude of the problems. A major segment of Phase II of the Ethnic Minority Study will be devoted to gathering the data necessary to develop an accurate picture of the problems of Asian Americans and to determine the extent to which DHEW programs are dealing with these problems.

¹ A Summary of Asian American Problems, OAAA, OSC, DHEW p.2

II. C. Asian Americans

2. Japanese Americans

There are approximately 591,000 Japanese-Americans. 73% are located in California and Hawaii (Region IX).¹ Some Japanese moved East after being released from internment camps at the end of World War II. Having lost their jobs and property, and unwilling to return to the anti-Asian hostility on the West Coast, they moved to eastern cities such as New York, Chicago, Philadelphia, Detroit, and Boston, where opportunities were less restricted.²

Japanese began immigrating to this country in substantial numbers as a replacement for Chinese labor after the enactment of the Chinese Exclusion Act in 1882. By 1907 there were approximately 70,000 Japanese in the United States. Immigration was sharply curtailed in that year, however, when Japan was forced to sign the "Gentlemen's Agreement" to voluntarily restrict immigration to this country. The passage of the Japanese Exclusion Act in 1924 ended even that restricted flow by prohibiting the entry of all Japanese nationals except for temporary education, business or diplomatic purposes.

1 Final 1970 population counts by race announced by Census Bureau, Department of Commerce, Census Bureau, October 20, 1971

2 Asian American Involvement and Identity, Kazuo Muiyoyama

The history of these Japanese immigrants is one of recurring prejudice and repression. The enactment of the Alien Land Laws in 16 western states beginning in 1913 and continuing thereafter, severely circumscribed the lives and fortunes of Japanese-Americans. The laws denied them the right to purchase or own land, including homes in which to live. College-trained Japanese were barred from many professions, and businesses, and employment opportunities. Labor unions refused them membership or tolerated segregated unions on a limited basis. Japanese-Americans were forced to live largely in "Japtowns", "Little Tokyos" and "Little Osakas", or were forced to be sharecroppers or stoop laborers on the farms.

As a result, the Japanese, like the other Asian-American groups, have a large impoverished elderly class. These, the Issei, first generation Japanese who came here in the early part of the century are congregated together in small Japanese-American communities of large metropolitan areas of the West Coast where adequate care is not available for them. Many are bachelors or elderly couples who lost their hard-earned possessions during the evacuation and

internment during World War II, only 38% of all Issei are living with a spouse.¹ The Issei carry a particularly heavy burden in this regard because many lost Social Security credit and private pension benefits when they were interned during World War II. Due to these problems only 1% of the Issei over 65 years of age in Honolulu were found to be on Social Security.²

The 1972 Amendments to the Social Security Act give Japanese Americans, who are United States citizens, Social Security credit for time spent in internment. For no apparently logical reason, the provision excludes from the benefits those who were interned and who are otherwise eligible for Social Security, but who are permanent residents or who became citizens after the internment. This discriminatory, or at least insensitive, restriction should be amended out of the legislation rather than to permit a second injustice to be heaped on the first one. Also unless a vigorous effort is made to insure that all who stand to benefit are informed about the new action, it can be expected that a substantial number of Japanese Americans will fail to get the benefits to which they are entitled. Also, the provision applies only to those Japanese Americans who are American citizens.

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1. "Aging Among the Japanese Americans, a paper by Ford Kuramoto, July 28, 1971. p.2
 2. Ibid.

On the other end of the age spectrum is the Japanese-American youth. In pre-World War II days, strong family unity resulted in an outstanding record with very few instances of juvenile delinquency, crime, or social deviancy. The evacuation and internment during World War II broke down the family unity and the subsequent generation of Japanese-American youth in the urban-inner city areas suffer from the same distressing problems in a similar severity and scope as do the young of other troubled minorities. Among Japanese-American youth, juvenile delinquency, drug abuse, low achievement, dropouts, and problems related to such are accelerating at an alarming rate.

A Japanese-American Citizens' League study in predominantly Japanese-American schools in Los Angeles found that the reading scores in those schools were significantly lower than the national average.¹ The most serious problem experienced by Japanese-American youth is drug abuse. It has been estimated that 95% of all Japanese-American juvenile arrests in Los Angeles County are drug related.²

¹"The Japanese American Experience." op. cit. p. 7.

²Proposal for an Asian American Drug Abuse Program submitted by the Asian of California Community Health Organizations, July 24, 1972.

II. C. Asian Americans

3. Chinese Americans

There are approximately 435,000 Chinese Americans. Fifty-one percent are located in California and Hawaii.¹ The remainder is found in middle and large sized cities throughout the country. The pattern of their distribution is a factor of the history of the Chinese American experience of economic and racial discrimination in the United States.

The Chinese were the first Asians to be brought to this country prior to the Civil War in response to the demand for cheap labor. They were recruited to work on railroad construction, in the mines and to a lesser degree, as cheap farm hands. Chinese Americans were brought into the South after the Civil War to replace the blacks as a source of cheap labor. Others were brought into the East in the late Nineteenth Century as strike breakers and to perform jobs that were not competitive with whites. Through long series of anti-Chinese legislation and discriminatory practices they were driven out of the key railroad and mining industries to settle in urban centers to perform jobs in laundries, restaurants, service industries and unskilled factory work that whites did not want to perform themselves.

The Chinese Exclusion Acts of 1882 and the Quota Act effectively prevented Chinese from bringing their wives and children to the United States. In 1960, with the Refugee Escape Act, new Chinese immigrants started filtering into this country as refugees from Communist China. Under a special

¹ A Summary of Asian American Problems, by the Office of Asian American Affairs, OSC, DHEW, p. 3, 5.

Executive Order, about 15,000 were admitted between 1962 and 1964. With the new Immigration Law in 1965, the number of Chinese entering increased dramatically. 17,000 entered in 1972; 108,000 have entered since 1965, causing serious problems in language, jobs and housing and burdens to the Chinese communities in American urban centers. It is estimated that of these recent immigrants, 80% have severely limited English ability.

The Chinese community to this day has remained mainly isolated, and even well-educated Chinese suffer from job discrimination. Many still remain within the ghetto and must compete for low-paying menial jobs which often represent the only employment available to them.

Studies conducted in California in 1965 indicated problems of severe poverty among Chinese Americans. It was found that the average family income of Chinese Americans in California was \$3,805. 40.8% had less than an eighth grade education.¹ Chinese American unemployment in San Francisco and New York in 1960 was twice the national average.² Chinatown, San Francisco has the "worst housing conditions in the San Francisco Bay Area", according to a report released by the San Francisco City Planning Department in 1972.

1 State of California, Department of Industrial Relations. Californians of Japanese, Chinese and Filipino Ancestry, 1965.
2 Baccari, Alessandro, San Francisco Chinese Community Citizens Survey and Fact Finding Report, August 15, 1969, and "Notes from the New York Chinatown Health Fair".

The influx of immigrant Chinese who have to live in Chinatown because of their limited English language facility have so crowded Chinatown that it is estimated that its square mile has the second highest (next to Manhattan) population density in the United States.¹ Suicide and TB rates of Chinese Americans in California are among the highest of any recorded group. Only recently has the Filipino TB rate exceeded that of the Chinese in San Francisco.

The ethnic consultant's report cites a long series of important studies, mainly local to San Francisco, that would have afforded a gold-mine of information about the Chinese community and its problems. Unfortunately, the data contained in the reports were rarely cited and access to the data was not available to the Contractors. For further expansion of ethnic profiles during Phase II, these reports can be obtained by the sub-contractor for the Asian American Field Study and pertinent data extracted. Because of the limited studies available, the knowledge of the problems of the Chinese community remains relatively shallow and incomplete. Areas such as child welfare, bilingual education, adult education, senior citizens, language, consumer protection, and economic and legal problems remain largely unexplored and undocumented. No study has been made on the impact of public and private agencies on the needs of the Chinese community.

There has been evidence of a vast under-utilization of DHEW services and benefits. In San Francisco, Chinese Americans

¹City and County of San Francisco, Dept. of City Planning
Chinatown: 1970 Census Population and Housing
Summary and Analysis August 1972.

account for 16% of the poverty population. It is estimated that the majority of the 16% represented families in poverty,¹ but only 4% of those are on Aid to Families with Dependent Children (AFDC).² The study also found that 34% of those surveyed have never had a physical check-up.³ The conditions in other Chinatowns throughout the country, while less documented is probably just as bad. In the past few years, major newspapers in cities such as New York, Boston, Los Angeles, Oakland, Chicago, Sacramento, Washington, D.C. and Seattle have published series of articles on the plight of their respective "Chinatowns", indicating problems of such severity as to attract the focus of the community at large. Studies based on San Francisco's "Chinatown" probably present a brighter picture than elsewhere since other cities have not had the token benefits of pilot poverty programs that have been established in San Francisco's Chinatown.

There are insufficient bilingual services to meet the needs of the elderly and newly arrived. The three Title VII bilingual programs for Chinese funded by the Office of Education served only 1,000 of the estimated 20,000 Chinese American students who need such services; and with 17,000 new arrivals yearly, most with only rudimentary knowledge of English, the need will rapidly intensify.⁴ The provision of adequate bilingual services is complicated by the fact that there are three distinct Chinese dialects: Mandarin, Cantonese and Toishanese, and while most of the newly arrived Chinese immigrants and their

¹ Estimate by Office of Asian - American Affairs OSC, DHEW

² Baccari, Alexandro, San Francisco Chinese Community Citizens Survey and Fact Finding Report, August 15, 1969

³ The Chinese Community: An Information Resource Survey, p.10.

⁴ Ibid. p.5

children speak Cantonese, most of the teachers in the schools serving Chinese children are Anglo and/or non-Cantonese speaking.

Many of the newly immigrated Chinese young have come under the influence of the alienated youth and drug sub-cultures . . . orientations and philosophies conflict with more traditional ways. Thus many of the young who have recently arrived from Hong Kong are hostile, alienated, and almost untouched by the schools and the social agencies who relate to and are controlled by the older generation which has difficulty understanding. The ancient "Six Companies" in San Francisco have become benevolent associations anxious to protect the image of the Chinese community and its substantial role in business and finance. Thus even the Chinese community agencies have had difficulty in relating to the immigrant young.

There has been an apparent reticence on the part of the leadership in Chinatown to assert the community's rights to public resources and services. It was not until the mid-1960's that the first substantive efforts were made to deal with the problem of poverty in Chinatown;¹

¹
The Chinese Community: An Information Resource Survey, Ling-Chi Wang, p.8.9.

In the beginning of the 70's, HEW began to take note of the serious problems in Chinatown. Social and Rehabilitation Services (SRS) funded a delinquency prevention program and the first pilot program of Title VII ESEA for the Chinese was funded. Limited resources, programmatic limitations and excessive bureaucratic red tape have so far prevented these programs from having any decisive impact on the community. Rigid HEW guidelines designed from a national perspective primarily for Whites and Blacks have frequently rendered the Chinese community ineligible for services. Lack of sensitivity to the special needs of the Chinese community on the part of HEW has contributed to the problem.¹

Phase I ethnic consultant reported:

"Language barriers, cultural differences, prolonged denial of civil rights and political, economic and social isolation are among the major barriers preventing the Chinese community from having access to vital services through state and local agencies funded by HEW. Since numerically the Chinese community is a minority among the minorities and since politically, the Chinese community has been cut off from meaningful participation, the needs of the Chinese community as a rule are ranked lowest in the list of priorities by the community at-large and social-welfare planning agencies. Unless special legislative and administrative provisions are made to focus attention of the special needs of the Chinese community, it is unlikely that major problems experienced by the Chinese community could be resolved in the foreseeable future.

Before this survey on recent studies on the Chinese community in the United States is concluded, it is important to point out that the problems in San Francisco Chinatown is by no means unique. Same problems in varying scales and intensities exist in Chinatowns throughout the United States. Even though the population

¹ The Chinese Community: An Information Resource Survey, Ling-Chi Wang, p.9.

figures in these Chinatowns are not as large as San Francisco Chinatown, these often hidden small communities have been more neglected than that of San Francisco Chinatown. They have yet to derive the token benefits San Francisco Chinatown received during the civil rights and anti-poverty movements in the late 1960's. The U.S. Department of Health, Education and Welfare has yet to discover them. San Francisco Chinatown at least can boast a few publicly funded community agencies and some token bilingual personnel serving the needy and the elderly, Chinatowns in other parts of the United States can name virtually none. This lack of community services has resulted in a conspicuous absence of available studies and information on their social and economic problems."¹

Among the Chinese population in New York City, 50% did not have any health insurance in 1969.² A study conducted by the Japanese American Citizens League (JACL) shows that 34% of the San Francisco Chinese population have never had a physical examination and another 50% have never had an eye or dental check-up. Lack of bilingual personnel at public health facilities further inhibits non-English speaking Chinese from utilizing the service that is available.³

The arrest figures for Chinese juveniles in San Francisco has increased by 600% over a twenty year period from 1950 to 1970. While the 600% increase may be explained in part by the increased immigration since 1965, the trend began in 1962 and per capita arrest figures have increased by about 300%. The rise in arrest rates, large number of drug overdoses, the number of murders in San Francisco's Chinatown (9 known murders in one year) and the various shootings that have occurred in New

¹Ling Chi, the Chinese Community, p. 2

²Notes from the New York Chinatown Health Four, 1971

³Japanese American Citizens League, Asian American Issues, 1971

York City's Chinatown and the Los Angeles Chinese community give indication of a very desperate situation in those three cities. The problems encountered by foreign-born (and even American-born) youth in the schools, the lack of employment opportunities, the inadequacy of social and recreational outlets, and the pervading poverty must be dealt with if this grave situation is to improve.

An estimated 90% of the elderly Chinese in San Francisco¹ and New York City have severe difficulties with the English language.² A majority of the Chinese and elderly residing in large cities have been forced to live in one room units, paying rents that are far beyond the means of their limited income from Social Security, pensions, and life savings. The lack of culturally relevant social and recreational outlets have forced many into living a lonely, isolated, day-to-day existence. The number of elderly in the Chinese communities is disproportionately higher than the national average. Over 13% of the total Chinese population in San Francisco are comprised of the elderly.³ There are no figures on the number of Chinese elderly eligible for Social Security Medicare, Old Age Assistance and other elderly oriented programs. Nor are there figures on the actual number receiving benefits under those programs. But reports from communities indicate a great discrepancy between those eligible and those actually receiving benefits. The lack of bilingual/bicultural outreach and bilingual informational materials would be a prime factor.

¹Baccari, Alessandro, San Francisco Chinese Community citizens survey and Fact Finding Report - August 5, 1969

²Chinatown Report of 1969, Chinatown Study Group N.Y.C.

³A Summary of Asian American Problems, the Office of Asian - American Affairs, OSC, DHEW, p.7.

II. C. Asian Americans

4. Filipinos¹

Though Filipino-Americans are a relatively large subgroup (343,000), they are often not perceived as a distinct Asian-American cultural group. Because many have Spanish surnames, a product of Spain's long dominion over the Islands, they tend to be lumped by the uninformed with Mexican-Americans and other Spanish-Speaking groups. Despite the fact that the vast majority of Filipinos do not speak Spanish but, rather, Tagalog or one of the many other related Filipino languages.² Many school districts lump Filipino children into Spanish bilingual programs, if they recognize a language problem at all.

Three distinct waves of Filipino immigration to the United States took place over the past 70 years. Following the 1907 "Gentlemen's Agreement" with Japan, which ruled out any continued importation of Japanese cheap labor, single young Filipino men were increasingly recruited to work in the fisheries of Alaska, the sugar plantations of Hawaii and the San Joaquin valley of California. The farmers in cooperation with the steamship companies ran publicity campaigns in the

1 Unless elsewhere designated, the data source is the ethnic Consultant's Report.

2 A Preliminary Proposal in Bilingual Education for Filipino/English Speaking Children, San Francisco Unified School District, March 1, 1972.

Philippines and Hawaii for Filipinos which characterized the continental United States as a "land of promise", and guaranteed education to students, and good paying jobs to the poor and uneducated. The 1924 Immigration Act, which established quotas based on nationality and race, and virtually prohibited the immigration of Asians, notably Japanese and Chinese, did not, however, apply to Filipinos who were "nationals" rather than "aliens". (At that time the Philippines was a United States' possession and thus Filipinos could enter the country in unlimited numbers.)

On arriving in the United States the Filipino newcomers, essentially single, male, and between the ages of 16 and 30, were bussed into labor camps around the western states to ensure a cheap supply of stoop labor. Those who preferred city life were hired as houseboys, waiters, busboys, cooks, chauffeurs, elevator boys, etc.

In 1935 the Philippine Commonwealth Act ended the period of free immigration and imposed a quota of 50 Filipino immigrants per year.

Among the extreme hardships placed on Filipino Americans by the Commonwealth Act, was the indefinite separation of many husbands from their Filipino wives

and children still on the Islands whom they had intended to bring over once they had earned enough money for their passage. Many Filipino workers in the U. S. never saw their families again. As a result, the immigration freeze produced a very homogeneous Filipino American population--male (94%) and young (84.3% were under 30) [California figures]. Anti-miscegenation laws prevented young Filipinos from freely intermarrying; racist legislation and restricted job opportunities confined him to the lowest economic and social classes. Not until 1946 did naturalization become possible; not until 1948 did caucasian "Malay" intermarriages become legal. But the wave of solicitous legislation following World War II could not undo the damage and many early immigrants, now in their late 30's, still prevented by the Immigration Laws from bringing their wives or other Filipino women into the U.S., remained permanently single and outside the mainstream of American society.

The second large group of Filipino immigrants came after World War II and consisted of men who had served in the U.S. Navy or Philippine Scouts and were thus allowed citizenship. Those who came to California often settled in cities (San Diego, Los Angeles, San Francisco, Monterey). Since many had at least a primary education,

and since discrimination had lessened somewhat against Filipinos, they were often able to find better jobs (cook, baker, factory worker, etc.) than their predecessors. Also, many entered civil service or government jobs, and as U. S. veterans were given special preferences in examinations. Although many of these men had wives and families, they could not afford to bring them in the beginning and had to save money to gradually bring their wives and children over one or two at a time.

The third large influx of Filipinos began after 1965 with the change in immigration laws described earlier, and is continuing through the present time.

In 1972, 29,376 Filipinos immigrated to the United States, making the Philippines the second largest supplier, after Mexico, of immigrants to the U. S.¹ This group is composed largely of professionals with special skills who are allowed to immigrate from the Philippines under the "third preference" category (occupational preference to skilled persons) of immigration eligibility. Most of these Filipinos are from the urban area of Manila and have been trained as doctors, lawyers, engineers, teachers, nurses, medical technicians, etc.

¹ 1970 Annual Report of The U.S. Immigration & Naturalization Service.

Although this group has professional and highly specialized training, they have had great difficulties in obtaining positions commensurate with their training and backgrounds because of licensing and other barriers.

As things presently stand, a majority of the Filipino-trained professionals are not considered qualified by state, local or professional standards to enter their professions. In order to qualify most would have to obtain additional education to meet U. S. certification requirements and spend many months preparing for required State examinations. Few have the money and time to do this. (Since most Filipinos settle in California, the California situation is cited throughout.) In the case of teachers and other professionals applying for civil service positions, it was not until 1968 when a state law was reversed, that it was possible for Filipino-American Permanent Residents to compete in Civil Service exams. At present, only five Philippine institutions of higher learning are recognized in California as providing acceptable degrees to meet State Teacher Certification requirements.

Until three years ago all Filipino-trained dentists, (a profession in great demand in this country) were barred from taking Dental Board examinations and

thereby from practice in the State of California.

Educated Filipinos are forced to find jobs which are below the level of their training, or expected income such as laborers, secretaries, kitchen workers, etc..

Although there is little national data on Filipino poverty, local and state California studies are relied upon. Since 40% of all Filipino-Americans live in California, California would seem to be a reliable indicator that Filipino-Americans suffer from serious and largely unrecognized poverty. In 1960, in California, Filipino men had a median annual income of \$2,925, the lowest of any of the various racial or ethnic groups studied.¹ They are also one of the fastest growing populations with the highest birth rate of any ethnic group in San Francisco. In addition, Filipinos have the second highest rate of immigration to this country. Filipino population in the U.S. has almost doubled in the last decade.

Filipino-Americans also have a disproportionate share of health problems in San Francisco. While they constitute 3.4% of the San Francisco population, they

¹ U.S. Census Report 1960.

account for 8% of the premature births and 10% of the reported cases of tuberculosis, a TB rate four times the city average.¹ 64% of the reported T.B. patients were diagnosed as having advanced cases² which indicates reluctance to seek medical aid and/or the unavailability of medical aid, in the face of obvious need.

A study undertaken at the San Francisco General Hospital reports that Filipino newcomers are not utilizing their services since they associate going to a "charity ward", with a loss of self-respect. The charity ward in the Filipino Urban Hospital is viewed by Filipinos as a last resort; as a place where poor people come to die. However, many of the newly arrived immigrants are not able to afford non-public medical services and do not have jobs that pay for medical insurance and are, therefore, not receiving proper medical attention. Among the specific health problems noted by that hospital are: T.B., intestinal parasitic infestations in children, lack of adequate child care and nutrition and a lack of immunizations. It would appear that unless more culturally sensitive medical services and outreach are provided to Filipinos, the disproportionate incidence of health problems among Filipino Americans can be expected to continue.

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1. Chinatown, 1970 Census: Population and Housing Summary and Analysis, San Francisco Department of City Planning, August 1972.
 2. Ibid.

A California study found that Filipino adult males¹ averaged less than an eighth grade education.

The younger generation is also experiencing serious educational problems. The large influx of Filipino immigrants to San Francisco has brought in a growing number of children who enter the schools with little or no knowledge of English, even though English is taught to all Filipino students in the first and second grades and becomes the medium of instruction in the third grade and thereafter. The lack of fluency of these children is attributed to the fact that teachers in the Philippines are not native English speakers and students and teachers seldom use English outside of the classroom. In addition, due to the speech habits established by use of dialects, Philippine pronunciation patterns differ significantly from English spoken in the schools. Many students drop out of schools in the U.S. in frustration with the inevitable by-product of reducing their employability.

Yet there are no bilingual programs for Filipinos although there are programs designed for Eskimos - even though there are ten times as many Filipinos, indicating that Filipinos along with other Asian American groups are often overlooked by program planners. Nor are there

1. State of California, Department of Industrial Relations. Californians of Japanese, Chinese, and Filipino Ancestry 1965.

any known Filipino programs funded under Title I, ESEA, although they are clearly a poverty population and have evident language and other learning difficulties.

The 1960 unemployment rates for Filipinos (largest figures available with racial/ethnic breakdowns) showed rates of 9.3% for males and 14.5% for females in the San Francisco-Oakland metropolitan area. The unemployment rates are probably much higher now, and are believed by informed persons working with them to have reached alarming proportions.¹ Even Filipinos who are fluent in the English language, may have differences in accents which reduces their ability to communicate, which may be a cause for many employers to turn down Filipino newcomers as job applicants.

Summary

Filipinos are thus the fastest growing ethnic population group both by birth rate and immigration and one of the most impoverished. Their language, their pattern of immigration, their poverty and their cultural sensitivity must be addressed in a culturally responsive manner if services are to be effective. There is little indication that there is a consciousness that Filipino needs should be met by DHEW or the DHEW funded agencies, or that plans must be made to serve this rapidly growing population.

1. State of California, Department of Industrial Relations. Californians of Japanese, Chinese, and Filipino Ancestry 1965.

II. C. Asian Americans

5. Samoans¹

Population: According to an Office of Education study, 48,000 persons of Samoan descent live in the United States. Samoan community leaders in Hawaii report that 20,000 of that group live in Hawaii. Of the mainland population, 26,000 live in California. The greatest concentration, some 17,000, are in Los Angeles, of which 11,000 are in the Centennial and South Bay areas of Greater Los Angeles. The San Francisco Bay area draws another 5,000 with the remainder scattered in San Diego, Oceanside, and other coastal towns and cities.

Migration: American Samoans are considered U.S. nationals and the Immigration and Naturalization Service keeps no records of migration. Immigrants from Western Samoa, a territory of New Zealand until it gained its independence in 1962, are lumped into the category "Oceania" by the Immigration and Naturalization Service, preventing clear identification of this component of immigration.

The first trickle of immigration to the mainland began in the 1930's. The trickle grew after World War II when the Samoans who had enlisted in the Navy and Marines eventually made their way to Hawaii and the mainland. The greatest emigration from Samoa took place after 1951 when the Department of the Navy closed the naval base at Pago Pago.

¹ This section relies exclusively on secondary sources - newspaper and journal articles and a survey done in Oahu, Hawaii late in 1971 by the Samoan Task Force under the auspices of the Hawaii State Immigration Service Center. - Colin Watanabe - Ethnic Consultant for Phase I

The promise of greater educational and economic opportunities seems to be the chief lure of America. American Samoa, with an area of 76 square miles and a population of approximately 28,000, is neither highly industrialized nor a center of commerce. The government is the main employer followed by family-style businesses.

Samoan Communities in America: Settlement patterns reflect occupational patterns. The preference for coastal cities stems from the fact that many Samoan males find employment in marine-related fields - shipbuilding, heavy industry (usually found in cities with free access to water transportation), and the armed services, especially the Navy and Marine Corps. Women most commonly find work as nurses' aides in hospitals, convalescent homes, and homes for the aged.

Samoan American communities tend to be closed and cohesive, retaining much island culture in such matters as language, food, dress, and social organization. Extended families, headed by a family chief who is the unquestioned head of the house, tend to be large - ranging on the average between six and twelve members. Within the family a strong code of mutual assistance exists; any person related by blood, marriage, or adoption is considered part of the family and is entitled to help from other family members.

Unlike other Asian immigrant groups, the Samoan male-female ratio is balanced.

The Oahu survey (a survey conducted with the aid of resident chiefs in the various districts) revealed that youth dominate the Samoan population on that island. Over half the population - 54.6% - were under 18 years of age; only 13.4% were over 40.

The average educational attainment for adults on Oahu is about ten (10) years, or about a year of high school. Only 5.5% of the population reported a year or more of college. This may be due in large part to the fact that the population is young and that most potential students have not yet attained college age. Based on California data, the Samoans have the lowest educational attainment of any ethnic group in California.

The low level of educational attainment among Oahu Samoans is undoubtedly a major cause of the very high unemployment rate: 16.9% of the men and 19.6% of the women 19 and over report themselves to be unemployed (the unemployment rate for Oahu runs about 5 or 6%). Largely as a result of high unemployment, almost a third (30.2%) of Oahu's Samoan population receives some kind of public assistance (Food Stamps, Aid to Families with Dependent Children, General Assistance, Medical Assistance, Old Age Security).

Almost no information could be found on the condition of Samoans on the mainland, though one source estimates

that half of the Samoan population in California lives in poverty. It is clearly a matter which demands further investigation. This limited information indicates a population with a great need for the services made available through DHEW. There is virtually no information on the impact of DHEW services on Samoans. Hopefully, the Asian American survey being conducted in Phase II will broaden our knowledge of the need for and utilization of services by Samoans.

II. C. Asian Americans

5. Korean Americans¹

There are approximately 50,000 Koreans in the United States. Because they have not been recognized - at all - as a distinct subgroup by Federal agencies and only in passing by the Census, there is very little available information on them. Of the 50,000, over 70% are recent immigrants faced with all the language and cultural adjustment problems encountered by immigrants. Most Korean Americans (about 33,000) reside in Los Angeles, with New York City having the next highest concentration (3,500). Korean Americans tend to disperse throughout a city rather than to live in community enclaves. This intensifies their problems of non-visibility and also inhibits the formation of Korean American community organizations to provide a delivery mechanism for services for, and advocacy in behalf of, the Korean American population. This results in a particular hardship on the elderly Korean Americans who have virtually no culturally familiar facilities to go to.

The rate of Korean immigration is escalating rapidly. From 1965 through 1968, the average yearly immigration was 4,000. In 1969, the influx rose to 6,000; in 1970 to 9,300. In 1971 it jumped to 14,000; in 1972 it rose again to 18,000.

¹Data based on Ethnic Consultants' Report.

Most Korean immigrants arrive with little or no knowledge of the English language and without cultural preparation of any kind for their new environment. However, some of the recent Korean immigrants are fluent in English, highly skilled and well-educated. These people are, however, still facing difficulties with cultural impact, and in finding employment, medical services and food. One of the major reasons for difficulty is that their skills and knowledge are not always readily transferable to American industries, the difficulties experienced in obtaining accreditation for training and education received in Korea, and the continuing social prejudice against Asian Americans. It is also important to note that there are virtually no facilities where they can get bilingual information regarding their employment and no facilities have been assigned to provide them with the small amount of retraining they need upon their arrival in the United States.

Given the virtual total absence of any data on Korean Americans and the absence of any programs specifically designed to serve them, DHEW and its funded agencies are not prepared to assist this rapidly growing Asian American subgroup.

II. C. Asian Americans

7. Asian American Highlights

- a. There is not enough information available on Asian Americans to get even a consistent and clear rudimentary picture of their problems and service needs in the areas of health, education or welfare. However, the little information available does indicate that there is severe poverty in many segments of Asian American communities. A major effort will be made in the Phase II follow-up study to develop an in-depth comprehensive portrait of the Asian American subgroups. Only with the development of a definitive base-line picture of Asian American problems and needs can rational and comprehensive planning for Asian Americans be effected.
- b. DHEW does not keep beneficiary or other data on Asian Americans by group or subgroup and it is therefore difficult, if not impossible, to determine to what extent they are being served.
- c. Elderly Asian Americans, particularly Japanese, Chinese and Filipinos, desperately need basic, culturally sensitive, health and welfare services.
- d. Newly arrived Asian American immigrants need bilingual services to help them with the problems of transition and to enable them to use their skills and training in order to obtain self-fulfillment for themselves and to provide services to the country that are often sorely needed.

- e. Preliminary analyses of available data and information obtained in Phase I indicate a pattern of differential need among the five Asian American subgroups, ranging from moderate to severe. Several groups have problems in common. Although the degree of severity of need may vary among the groups, there are consistent indications that the availability of services is woefully inadequate whatever the degree of need.
- f. There is a pattern of systematic neglect of Asian Americans as a specific consumer target group at all levels within DHEW.

II. D. American Indian¹

1. Overview

According to the 1970 U.S. Census, there are 792,730 Indians in the United States. Their population has grown over the past 10 years at 2.4 times the average rate of growth for the nation.² There is a high birth rate and the median age of Indians is 17 years,³ twelve years below the national median of 29.³ Of the total Indian population, an estimated 440,000 live on Federal reservations while 350,000⁴ are living in urban areas, rural areas and on land that is not held in trust by the Federal government such as State reservation and terminated reservations. It is unfortunate

1 Data quoted that is not otherwise cited derives from the Indian Consultant's Report.

2 The rate of growth for U.S. 1960-1970 is 18%, the rate of growth for Indians 1960-1970 is 46%.

3	<u>U.S.</u>	Indians	Alaska Natives
	(23 Reservation States)		
Median Age	29.5	17.3	16.3

Sources: U.S. Bureau of the Census, U.S. Census, U.S. Census of Population: 1960

U.S. Population: General Population Characteristics, U.S. Summary.

Final Report PC(1)-1B Indians and Alaska Natives: Subject Reports.

Nonwhite Population by Race, Final Report PC (2) -1C. Table 51

4 Bureau of Indian Affairs Report 1972 "Indian Eligibility for Bureau Services".

that American Indians are continually defined by the place where they live. In many ways, the terms "Reservation," and "Urban" or "Non-Reservation" Indian," are artificial categories whose primary function has been to divide Indians and foist intra-Indian conflict. The categories tend to brush over the common ties of culture and world view which are much more of an integral part of Indians' self-definition and self-image than the place where they live. Generally Indians feel they are Indians wherever they live and are becoming increasingly critical of the divisive manipulation of the categories, "Reservation" and "Non-Reservation." These categories have often been used as an excuse by the BIA not to serve almost one half of the Indian population. IHS admits its responsibility to serve Indians who live off the Reservation but has not been given the resources to do so. On the other hand, other DHEW programs and funded agencies for the most part have not moved in to fill the void. The use of these categories has also resulted in Indian groups fighting among each other for the limited resources made available to serve the needs of Indians and has kept them from focusing on the underlying problem of the total inadequacy of the resources, how to obtain a larger proportion of available funds, and how to better utilize those funds which are available.

An Indian does not suddenly and dramatically alter his identification or his way of looking at the world just by moving from a reservation to a non-reservation area; nor is the Government's obligation to him diminished

by the move. The thing that does change is the mechanisms for delivering services to him; and for this limited purpose the discussion will be divided into sections on the delivery of services to Indians on Reservations and delivery of services to Indians in Off-Reservation areas.

2. Reservation Indians

a. General

440,000 Indians live on approximately 290 Federal reservations, on land held in trust by the Department of the Interior. The reservations range in size from the 25,000 square mile Navajo Nation with a population of 140,000 to small bands or communities of a few hundred living on a few acres of land. Culturally, each tribe is distinct -- speaking different native languages and following unique tribal customs. Cultural retention of each tribe (or tribal members) depends upon the influence of Western culture, from nearly total assimilation to strong retention of traditional life styles.

Precise figures on Indian poverty are not available and won't be until the Special Census report on Indians is issued in the Spring of 1973. Nevertheless, it has been estimated that the yearly family income on reservations is about \$1500, that unemployment runs at least 50% and that 90% of reservation housing is substandard. The average life

expectancy has been reported varying from 47 to 64 years.

b. Education

Slightly over half of all Reservation Indian students attend public schools; most of the other half attend federal boarding schools, with the remainder in mission(church) and other private schools. The average educational level for all Indians under Federal supervision is five school years and more than one-fifth of all Indian men have less than five years of schooling.¹ The dropout rate is estimated as being anywhere from 45% to 60%.² Numerous studies have found that the school environment is a very hostile place for most Indian children. Two thirds of Indian children attending

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"There are nearly 300 Indian languages in use today in the United States. More than one-half of the Indian youth between the ages of 6 and 18 use their native language. Two-thirds of Indian children entering Bureau of Indian Affairs schools have little or no skill in English.

At the same time, a substantial number of the teachers instructing Indian children are unfamiliar with the only language their Indian students understand. It is estimated that less than 5 percent of teachers in BIA schools are native to the culture and language of the Indian children they teach. Thus, thousands of Indian children who know only their native language are taught by teachers who essentially know only English"] Based on 1969 Report of the Committee on Labor and Public Welfare - United States Senate - made its Special Subcommittee on Indian Education.

2

From, "National Advisory Council for Educationally Deprived Children," Annual Report. 1971.

BIA schools arrive at school speaking one of the 300 Indian tongues, rather than English.¹ Less than 5% of teachers of Indian grade school children are native to the culture and language of the children they teach. So most children are taught in a language they may not understand by a teacher who is probably white and who, consciously or unconsciously, is conveying an attitude to them that white ways are superior to the customs and values they have been exposed to from the time they were born until the time they entered the classroom. While the days of having their braids cut off and their names changed are over for the most part, many of the damaging hostile attitudes remain. This indicates a need for a major commitment to develop culturally and linguistically sensitive educational programs premised on respect for Indian students as Indians and designed to present as part of the educational process their cultural richness and tribal heritage intrinsic to their lives.

c. Health

Indians have severe health problems. Although the health situation has improved considerably over

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Bureau of Indian Affairs, Report 1972 "Indian Eligibility for Bureau Services".

the past 18 years since the Indian Health Service was transferred from BIA to DHEW in 1955, it is still seriously below the national norm.

The mortality rate from tuberculosis is 3.5 times higher than the national average; pneumonia is 3.4 times higher; and meningitis is 9.4 times higher. Infant mortality is 1.4 times higher than the national norm. Interestingly, the infant mortality rate is relatively normative for the first month of the child's life, but rises to three times the national average for the second through twelfth¹ month of the child's life. This seems to indicate that the high rate of infant mortality is at least in part the result of the harsh home and environmental conditions including bad water supply, poor sanitation, inadequate heating systems, etc., which await the infant after he or she leaves the hospital.

Also, transportation to hospitals and clinics is a major problem on reservations, many of which are vast open spaces with low population density and inadequate road systems. Time and distance discourage Indian access and use of medical facilities.

Many Indians, including many of those who have left the Reservation, have a culturally different perception of what is important to observe in signs of illness and what is necessary to report to the

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Based on data from National Center for Health Statistics
HSMHA, DHEW 1955-1965.

doctor during the diagnostic process. Lack of comprehension of the Indian's view of his health problems on the part of non-Indian health personnel impacts the effectiveness of health service delivery. While Indian medical personnel would more likely be sensitive to these different perceptions, there is a woeful shortage of trained Indian health personnel. There are only 38 Indian doctors in the country and only one of them is working on an Indian reservation. There are only approximately 350 Indian registered nurses on and off the reservations or 42.3 R.Ns for every 100,000 Indians as compared to a national ratio of 368 for every 100,000 persons in the general population. Training for Indians in the health paraprofessional fields (such as assistant doctors and nurse-midwives which are now beginning) need to be increased. Although some training of practical nurses (and in a few other similar classifications) has been available on a limited scale in the past, there is a need to substantially increase the effort in this area also.

d. Tribal Governments, Regionalization and Revenue-Sharing

Indians have a unique formal structure for self-government. Reservation Indians are governed by their Tribal governments which are jurisdictionally autonomous from the state and, therefore, not subject

to state control. Tribal governments provide a varied range of services to tribal members, including social welfare, legal services, employment, etc., depending upon the financial resources of the Tribe and the level of development of the government. But all Indian tribes have the legal capacity and potential to deal directly, as local governments, with Federal agencies for the provision of services to their members. More so than any other governmental mechanism (State, County, City), the Tribal governments are capable of being sensitive to the cultural characteristics of their people.

For legal, historical and functional reasons, Indian tribes have developed a deeply rooted and exclusive relationship with the Federal government. The Courts have defined it as a "special relationship," and the tribes see it as one. They look to the Federal government to fulfill its obligation to provide Indians with health, education, and welfare resources and view the delivery of such services as the outgrowth of a commitment that is rooted in treaties and laws, and confirmed in practice.

On the other hand, tribal governments have no "special relationship" with state and county governments. If any relationship exists at all, more often than not it is a mutually antagonistic

one. Experience has shown that state governments are seldom willing to provide Indians a fair share of formula grant Federal funds, claiming that Indians are a Federal responsibility and burden, despite the fact that States frequently count Indian populations in their representation of need to federal agencies. In the view of most tribes, transfer of Federal responsibility for Indians to the states (a practice known as termination) would be more than a breach of a long commitment. It would undermine and destroy the "special relationship" and replace it with, at best a vacuum and, at worst, a hostile one. The few cases of termination of Federal services to Indians by transferring responsibility to the states (Menominee and Klamath Tribes) have proven to be such disasters that the Federal government has had to re-enter the picture and take on the costly process of picking up the pieces.

A study report by the Office of Management and Budget (OMB), in March, 1972, concluded that "All Federal assistance programs should eliminate the requirement for Indian tribes to work through states except where required by law and the decision, without any form of encouragement, should be made by the tribal council with an option of direct dealing with the Federal government." The President has

already proposed that Johnson-O'Malley funds be channeled directly to the tribes, rather than through the states.¹ DHEW should consider adopting a comprehensive policy of treating tribes as equivalent to local or state governments whenever funds are to be channeled directly to the state or local level. Precedent for such a policy was established under the recently enacted General Revenue Sharing Act which recognized Indian tribes as "local units of governments."

3. Non-Reservation Indians

The 40% of the Indian population which do not live on reservations constitute a distinct subculture of American Indians, with unique characteristics and problems. The terms "Urban Indians," "Off-Reservation Indians," and "Non-Reservation Indians," are commonly used to describe this population. This group includes numerous persons of Indian descent, rural and urban, who have never lived on Federal reservation but who continue to identify as Indians. It also includes Indians living on state reservations and those living on reservations for which Federal responsibility has been terminated as well as reservation Indians who migrated or were relocated by the BIA in urban areas. In addition, many Indians live on the urban fringe or in border towns or rural areas close to the reservation.

¹ The President's Indian Message to Congress, July 8, 1970.

a. Rural Indians

There is very little descriptive material on Indians living in rural non-Federal reservation areas. They are the least known, least visible Indians in the country. A quarter of a million Indians live east of the Mississippi River. Since most live off Federal Reservations they are not within the scope of so-called "traditionally served Indians and are denied benefits of BIA and IHS programs which serve Indians on Federal reservations almost exclusively. Their invisibility causes them to be by-passed by most other Federal programs. State and local programs tend to overlook them because of their low concentration and because they feel they are a "Federal" responsibility - even though the BIA claims they are not.

b. Urban Indians

Indians living in urban areas are found in small clusters in large urban areas throughout the country. Many came to their urban areas as a result of the BIA's recently discontinued Relocation policy, which, for 25 years was to drain the reservations by relocating Indians to off-reservation areas. The traumatic transition from reservation to urban life took its toll. Most of those relocated sank immediately to the bottom of the urban heap. According to the President's Indian Message of July 1970, approximately three-fourths of them are living in

poverty. They suffer from the combined disabling effects of poverty, language and cultural difference, and urban culture shock. In addition, they have varying views about how much they want to assimilate into urban life. Some actively strive for assimilation, others actively or passively reject it, and many are torn between the two as demonstrated by the constant two-way flow between their new locations and the reservations.

Indians in urban areas have extensive difficulty obtaining even the most basic services. BIA services do not extend off the reservations, but many urban service providers do not understand this and refer them back to BIA offices which in turn refer them somewhere else. This lack of understanding, coupled with the states' traditional attitude that Indians are a Federal responsibility, causes Indians to get the run-around - going back and forth to city, county, state and Federal agencies, and being turned away by all of them. When they are able to obtain services they are from providers who usually know almost nothing about Indians. Because of the humiliation and run-around which they encounter, many will travel hundreds of miles back to the familiar services on the reservation, often at the expense of their jobs and their children's education. Others will simply forego help, except in the direst of emergencies.

c. DHEW and Non-Reservation Indians

At the present time, DHEW has no definitive overall policy or program specifically directed toward Non-Reservation Indians not living on Reservations. Non-Reservation Indian groups must compete for DHEW funds the same as any other ethnic group. In many cases, this has meant that Non-Reservation Indians have not participated in DHEW programs, since they generally do not have the same level of sophistication and experience in grantsmanship and proposal-writing as some other minority groups. Also, since Indians tend not to cluster or concentrate in one section of an urban area, they are not as visible as other minority groups, are not able to organize as readily, are not viewed as a problem and many identify with the reservation rather than the urban area in which they are presently living. Furthermore, where formula grant or block grant monies involve the necessity of Non-Reservation Indian groups negotiating with state agencies, this has usually proven to be a hopeless effort. An exception to the general pattern is the Office of Education within DHEW which has worked directly with Non-Reservation Indian groups in such programs as Emergency School Assistance Program and Libraries and Educational Technology, among others.

4. Coordination Within DHEW

Until relatively recently, the BIA had been the nearly exclusive contact between the Federal government and Indian people. But since the transfer of IHS to DHEW in 1954, this picture has changed rapidly and now HEW is a major source of funds and services for Indians. In 1972 over 23% of all funds for Indian education came from the Office of Education.¹ The Indian Education Act of 1972 is to be administered solely by DHEW through its newly created Bureau of Indian Education in OE. In enacting this legislation, Congress and the President have, in a significant way, demonstrated that they are in accord with the concept of an expanding role in Indian affairs for DHEW. There are also strong indications from both the President and Congress that DHEW's role in Indian affairs will continue to expand rapidly. Since the BIA has again rejected responsibility for Non-Reservation Indians, DHEW is, by default, the primary Federal vehicle for delivery of services to the 40% of the Indian population living off the reservations. Reportedly, under the proposed OEO reorganization plan, the Indian Division of OEO is to be transferred to DHEW. Under the Executive Reorganization Plan, the Secretary of DHEW has super-cabinet responsibility for all Indian matters, which raises DHEW's role in serving the needs of Indians to a new level of importance.

¹ Report of the DHEW Indian Education Task Force - FY 72

The burgeoning role of DHEW in Indian affairs has, however, tended to develop on an ad hoc basis, with little overall coordination or policy direction to guide the growth. Until the establishment of the Office of American Indian Affairs, Office of Special Concerns, there was no office in the Office of the Secretary in DHEW with the potential to provide this overview and policy development function of DHEW.

III. ANALYSIS OF SELECTED PROGRAMS REVIEWED IN PHASE I

A. Overview

At the outset, a decision was required on how many of the nearly three hundred DHEW programs would be included in the study. It was essential to look at the question from several perspectives, i.e., the respective concerns of each of the ethnic offices within OSC; from the point of view of the broad policy perspective of DHEW; the relative ease or difficulty anticipated in obtaining information on the program in the context of the limited number of programs for inclusion in the study. The more difficult option of reviewing at least ten programs in some depth was ultimately chosen, including studying state plans and obtaining available state and local data; and surveying at least twenty other programs in varying degrees of depth in order to be able to make a sufficiently comprehensive and generalizable case on the delivery of DHEW services to the ethnic minorities.

The programs studied in depth were: Vocational Education; Titles I and VII, ESEA; Education Professions Development Act; Head Start; Community Health Projects funded under a number of sources including Maternal and Child Health (SSA Title V), Public Health Act, Title III, and the delegated health programs from the Office of Economic Opportunity (OEO); Hill-Burton Hospital and Medical Construction; Vocational Rehabilitation; and Medicare. The other programs were examined for specific factors, i.e., employment of ethnic individuals, allocation of funds and participation of community groups, etc., to identify specific issues

in the delivery of services to the ethnic minorities.

Due to the limitations of time and the scope of the study, all information, evaluations, data, etc., were those readily obtainable from the offices of DHEW or from the states. No new surveys were undertaken because of the four-month limitation and since there was no time to clear survey instruments through OMB. The findings have provided an overview of the issues and problems that HEW must solve in order to better provide culturally sensitive services to the ethnic minorities.

III. ANALYSIS OF SELECTED PROGRAMS REVIEWED IN PHASE I

B. Hill-Burton Program

The Hill-Burton Program provides funds to assist states in planning for and constructing hospitals, public health centers, neighborhood health centers, long-term care facilities and other related health facilities. To qualify, a State must first submit a State Plan for Health Facilities. Funds are allocated to states by formula (population weighted by poverty population). Public agencies and private non-profit organizations may apply to the States for grants to cover up to two-thirds of the total eligible costs of a project, though certain incentives are available for projects in areas of particularly high poverty.

The legislative framework of Hill-Burton was designed not just to get hospitals built, but to expand the supply of hospital and other medical facilities for those who have the greatest need for them, particularly the poor. The Act makes the number of poverty persons in a state a factor in the allocation formula. Numerous safeguards and requirements were written into the Act to insure that funds would be used to serve those most in need of medical facilities and services. Health statistics make it clear that the poor and ethnic minority populations have the greatest need for health services and the least access to them. But in the end, the poor have encountered many barriers which have obstructed their utilization of hospitals built with Hill-Burton funds, because too many of the safeguards and requirements contained in the guidelines specifically to protect the interests of the poor have been ignored or circumvented.

1. Service Areas

The Hill-Burton State Plan guidelines require the administering agency of the state to divide the entire state into service areas, assess the relative needs of the areas according to a precise formula (need for medical facilities, poverty problems, etc.) and then rank the areas in terms of priority needs for health facilities and services. Funds are to be allocated to the service areas having the highest priority ratings. As specified in the guidelines, a service area is to be drawn to designate a cohesive and functional community for health facilities purposes. The guidelines list the various factors that should go into delineating the boundaries of a service area and make it clear that there is no necessary correlation between health service areas and political areas:

"Patient source data are extremely valuable and serve as the springboard for delineation of service areas. Conclusions reached through the application of patient origin data must frequently be adjusted, however, to compensate for inequities arising from the existing pattern of facilities. Studies of the socioeconomic, trade, geographic, transportation and time-distance, and other factors should also be considered in adjusting area boundaries... Area boundaries should not be established to coincide with city, town, or county lines unless such political subdivisions represent the most logical service areas for planning health facilities and services."¹

¹ P.H.S. Health Grant Manual 23-2. Chapter III

A GAO study of Hill-Burton found that these criteria were rarely followed in establishing service areas. Instead, there are indications that states have chosen political units to serve as service unit boundaries. The result is not the functionally designed health service areas foreseen by the guidelines or legislation.

In particular, counties are often designated as service areas for purposes of the Hill-Burton Program; county boundaries, however, are rarely drawn based on socio-economic, transportation or time-distance considerations. This perversion of the service area concept as intended by the Act specifically hurts the ethnic minorities by eliminating the easy access to facilities and the planning of facilities and services which benefit those most in need and which are responsive to the life situations of consumers - the social economic factors that were supposed to be considered in establishing service areas. Broad boundaries do enable an area to include a poverty area and a middle class suburban area within the same Hill-Burton service area. Such a process permits the designation of service areas with high priority ranking (and thus high probability of obtaining Hill-Burton funds) because of the poverty area included in it, but then locating the hospital in a middle-class area inaccessible and unresponsive to the poverty community.

Phase II of the Ethnic Minority study will examine the outlines of Hill-Burton designated areas to determine whether the service areas are gerrymandered to include middle-class suburban areas within the same area as central city poverty areas. If this is so then the location of hospitals that have

received funds from Hill-Burton will be examined to determine whether allocation of funds presumably to poverty areas have in fact funded programs in middle class areas.

For urban areas, Phase II will also examine the number of miles between a sample of hospital facilities and concentrations of minority populations, the presence of available transportation, the cost of that transportation, the frequency with which it runs during the day and night, and the length of time required to move an individual from a concentration of minority population to the hospital area. These factors were not examined in the GAO report and seem warranted on the basis of scattered information on the workings and non-workings of Hill-Burton Act supported facilities. Utilization of the county or city lines to designate service areas in express opposition to DHEW regulations suggests that pockets of poverty or of minority groups are not being benefited as foreseen by the authors of the Act.

2. Ranking Service Areas of Greatest Need

GAO also found that contrary to the legislative intent, high priority service areas are not the ones which ultimately receive Hill-Burton funds. What has happened, apparently, is that there has been a great demand for hospitals by new suburban communities that have come into being during the last 25 years. These wealthier communities, unlike the urban minority poverty communities, have found no difficulty in raising the local matching funds required to obtain Hill-Burton monies. The suburban communities, while low priority areas, can raise the

matching funds and thus apply for Hill-Burton funds. Poverty communities with high concentrations of ethnic minorities, while high priority, lack the matching funds or the ability to raise them, and thus cannot and do not apply. The highest priority communities which do not submit applications for funds completely drop out of the state's system of establishing Hill - Burton priorities. The state, through the State Plan, draws up the list of priority areas only from among those service areas which have applied. According to GAO, the state does not see that its role is to inquire whether financial need at the local level (i.e., ability to raise matching funds) is the reason why funds have not been sought from the areas with the greatest absolute need for health facilities. The guidelines should mandate that the priorities be based on relative community need rather than on the need of those areas of the community who apply (i.e., those who can raise matching funds) requiring the states focus on the high priority areas having the greatest need. The weakness in the guidelines - the listing of priority service areas - which the states have taken advantage of, has permitted the purposes of the Act to be vitiated. A vigorous monitoring effort would have prompted DHEW to take corrective steps to ensure that Federal funds accomplish the purposes for which they were intended. According to GAO, however, the limited view DHEW officials seem to have of their role as guardians of Federal monies and congressional intent precluded this from happening. A DHEW regional official stated to GAO

that neither the DHEW regional office nor the state agencies have attempted to determine why projects are not generated in service areas with the greatest need. The DHEW official commented that the state agencies should be responsible for making such determinations, because the Hill-Burton program is administered by the state.

The Hill-Burton Program has funded some part of the construction of one-third of the hospitals in the United States. There have been recent reports of an oversupply of hospital facilities in some areas. However, in the 1970 Amendments to the Hill-Burton Act, Congress emphasized the building of community health facilities desperately needed in poverty areas.¹ Because the ethnic minorities represent a disproportionate share of those persons in poverty, it is not likely that an oversupply of facilities exists in those communities with high concentrations of ethnic minorities. This point will be pursued in Phase II. In addition, preliminary analyses in Phase I indicate a need for hospitals and the rehabilitation of old hospitals in areas with high concentrations of ethnic minorities. A more assertive attitude by DHEW vis-a-vis the states in the infusion of Hill-Burton funds into the areas with the greatest need could have provided ethnic minorities with the health facilities foreseen under the Act-community oriented facilities that could be sensitive to their cultural characteristic and which, as indicated by the health statistics contained in the Ethnic Profile section, show they desperately need.

¹Medical Facilities Construction and Modernization Amendments of 1970; Public Law 91-296, 42 USC 291-291 (o). "...By adding after clause (3) the following new clauses: (4) in the case of projects for construction of outpatient facilities, to any outpatient facility that will be located in and provide services for residents of, an area determined by the Secretary to be a rural or urban poverty area; (Sec. 110.).

3. 90% Federal Matching

Congress has made an effort to reassert the original intent of the legislation by dealing with the problem of high priority areas which have been unable to garner matching funds and thus fail to qualify for Hill-Burton funds. The 1970 Amendments to Hill-Burton permit the state to fund up to 90% of the total costs of health facilities in poverty areas instead of the $2/3 - 1/3$ formula. But, again, the Congressional intent has been frustrated and the states have not utilized funds for this purpose.

In increasing the allowable Federal share to 90% for high poverty areas, Congress, however, did not appropriate additional funds. Almost all states have decided to spread their Hill-Burton funds to as many projects as possible and, according to GAO, they have universally decided not to permit a local community to obtain 90% of federal share. (Nor is the state providing the remaining share up to 90%.) For instance, in Texas the state has a mandatory maximum of 50% Federal share coupled with a million dollar limit enabling funds to be available for assistance to more projects. The state intends to continue this policy. The result of this policy on the part of the states has been that little or no increased Federal assistance under the Hill-Burton program to poverty areas has occurred. Many of these areas have substantial ethnic minority populations.

Since DHEW officials maintain that they cannot compel the state agencies to fund a Hill-Burton project at a 90% rate of Federal participation, the question might appropriately be referred to Congress to determine whether the law should be

The GAO report on implementation of Title VI of the Hill-Burton Act observes: "Not only did the HEW Regional Office itself not monitor, but it did not require the state agencies to monitor the implementation of poverty-related assurances."¹ The Hill-Burton legislation clearly requires such reasonable volume of service to the poor to be made available through the Hill-Burton hospitals. With the high incidence of poverty among ethnic minorities, such lack of criteria and standards for the reasonable volume of services requirement have inevitably operated to the detriment of the minority groups.

Thus, the Hill-Burton program, designed to benefit particularly those persons unable to pay, has, in practice, largely been a subsidized hospital program for the middle-class in which the rights of the poor and the ethnic minorities to service have not been protected.

On April 18, 1972, after 13 months of internal debate on the subject, HEW proposed new regulations in the Federal Register. The proposed regulations defining reasonable volume of service established as a guideline figure that hospitals should provide free care equal to 5% of the total services provided. However, reimbursements for Medicare and Medicaid are subtracted from total costs, although the cost of Medicare and Medicaid patients are fully covered by Federal programs. Most hospitals today derive about 40% of their revenue from the Medicare and Medicaid programs.

¹ Observations on the Implementation of Title VI of the Civil Rights Act of 1964, U.S. General Accounting Office, August 1972 p. 45.

Therefore the proposed regulations, in fact, call for hospitals to provide free care equivalent to an estimated 3% of their costs. An American Hospital Association's survey indicated that 85% of all Hill-Burton hospitals had not met those standards.¹

On June 13, 1972, the Federal Hospital Council (a body established by the Hill-Burton Act) met in a meeting closed to the public. (Under Executive Order 11671, published in the Federal Register on June 7, 1971, such meetings are required to be open to the public, for public participation.) This Council, with only seven members, despite a statutory requirement of a quorum of 12 members, including six consumers members, vetoed the proposed 5% regulation.

The new formula which has been promulgated, provides for 3% of costs exclusive of Medicare or Medicaid or 10% of the total of the grant per year over the past 20 years. This could exempt hospitals built prior to 1953 from all obligations to provide free care, since there is no way to document a hospital's non-performance during the past 20 years.

Under the new regulations, a state can reduce or waive the requirement of 3% free service for a facility by publishing a notice to that effect in a local newspaper. On the basis of this, a consumer group can make an appeal to the state. If the state reaffirms the reduced service to the poor, appeal can be made to the Secretary, DHEW. Dr. Granning, Director, Health Care Facilities, was asked whether a publication in a local newspaper

¹ Telephone conversation with Dr. Harold M. Granning, Director, Health Care Facilities Service, HSMHA, DHEW.

might be overlooked by ethnic minority groups most affected, and whether notification in the appropriate ethnic newspaper might more likely be noticed.

He was also asked whether notification to community groups or agencies representing or serving the minorities affected, with some explanation as to the implication of the decision and their right of appeal might not prove even more useful. Dr. Granning replied that there is a law of diminishing returns in notifying community agencies and that the act of publishing by itself served as a deterrent to violations of the assurance on the provision of free service to the poor.

The President's new budget calls for no new funding for Hill-Burton constructions, which means that for the time being the poor are not likely to get Hill-Burton hospitals and other health facilities constructed in their communities. The tendency within DHEW appears to be to view the primary objective of the Hill-Burton "program" as being construction rather than to facilitate the delivery of health services. This leads to the kind of logic which says, in effect, "no construction money, no program". However, hospitals have a function - the delivery of health services. Based on analyses of the legislation and guidelines, the clear objective of the Hill-Burton program is the delivery of health services through the construction of hospitals and other health facilities. This remains a crucial issue with regard to those Hill-Burton funded facilities which currently exist. With or without new construction monies, Hill-Burton still represents a major resource for health services - most particularly for the poor, and pointedly, the ethnic minorities.

With the seeming cessation of Hill-Burton construction, DHEW's vigorous enforcement of the reasonable volume of services regulation becomes the only way left for the poor - primary intended beneficiaries of the Act - to gain improved health services at all from the massive expenditures made under Hill-Burton. If anything, the case for enforcement of the "reasonable volume of service" regulation is strengthened, not diminished, by the cessation of new construction monies - particularly for the ethnic minorities.

The "reasonable volume of services" provisions are the last chance for the minorities to salvage some of their share of the Hill-Burton Act. Unless DHEW takes a more assertive role in enforcing compliance with the regulations and the intent of the Act, this country will have funneled \$4 billion into Hill-Burton without accomplishing the objective it set out to achieve.

Indians and Hill-Burton

Little attention seems to have been paid to the relationship of the Hill-Burton Program to Indians. Apparently the Indian Health Service contracted with Hill-Burton to build hospitals in communities bordering on Indian reservations. However, the arrangement included an agreement that Indians would only receive services at the hospitals when the services were paid for by Indian Health Service under its Contract Care funds. If this is the case, IHS is unnecessarily spending funds on contract care (funds that are needed elsewhere in IHS) since the hospitals should be required to provide at least some of

those services free under the "reasonable volume of services" provision of Hill-Burton. Such a policy, to the extent it exists, in effect, reduces the volume of health services available to Indians through IHS and Hill-Burton, thereby establishing a policy that would be in fact, if not in intent, discriminatory to Indians. This issue will be explored further in Phase II.

5. Civil Rights

A GAO investigation in Texas¹ disclosed that little effort is made by the State to insure that Hill-Burton facilities are in compliance with Title VI of the Civil Rights Act of 1964. For the initial clearance, the DHEW Regional Office depended primarily on the application for assurances signed by local communities stating that they are in compliance. No field investigations or evaluations were made at that time. The pattern, according to GAO, continued after the initial clearance. The Regional Office did not monitor on-going compliance but relied on information in its files and on the state's assurance that the local hospitals were in compliance. But the Texas State Commissioner of Health said that he relies on the DHEW Regional Office to discover discriminatory practices

¹Observations on the Implementation of Title VI of the Civil Rights Act of 1964 in the Hill-Burton Program, by the General Accounting Office, Comptroller General of the United States August 1972.

and believed that the compliance requirements for annual monitoring were not applicable to Hill-Burton projects.

The impression is that the absence of Title VI compliance monitoring found in Texas by GAO fairly represents the situation throughout the rest of the country. The field studies by the ethnic consultants found that the ethnic communities perceive serious problems of discrimination against them by medical facilities both in the delivery of services and in employment practices. A first step in providing culturally sensitive health services is to guard against or eliminate overt and illegal discrimination against ethnic minorities where it exists in Hill-Burton funded facilities.

III. C. Medicare

Hospital Insurance for the aged provides insurance protection for most of the reasonable costs of inpatient hospital services and post-hospital extended care services for persons 65 and over. Supplementary Medical Insurance which can be subscribed to in addition to hospital insurance pays for the cost of most health care not covered by hospital insurance, including the cost of physicians and other suppliers of medical services.

Medicare data is compiled in two statistical categories only: "White" and "Non-White". The individual Spanish Speaking, Asian American, and American Indian enrollees classify themselves into these categories¹ without any guidance. Census indicates that the Spanish Speaking, when forced to choose between "White" and "Non-White", classify themselves as White in 97% of the cases. Indians will rarely classify themselves as White. For Asian Americans, SSA could not estimate in which classification they would be found. As a result, varying percentages of the different ethnic minority groups can be found in both categories. This makes it impossible to determine whether ethnic minorities are signing up and using Medicare at the same rate as the rest of the population. This information is essential for the Medicare program, itself, to know if its outreach and other mechanisms are responsive to ethnic minorities. This information is

¹When applying for SSA, a new applicant fills out a form which includes the question, "White" or Non-White". The SSA official has no guidelines indicating which ethnic group belongs in which category so the decision is left to the preference of the applicant.

also important to DHEW for its long-range planning. Since Medicare is the primary medical resource of most ethnic minority elderly, knowing the rates of usage would enable DHEW to draw a fairly accurate picture of how much medical care ethnic minorities are actually getting, and determining therefrom the supplemental and special services which may be required to stimulate maximum utilization by the ethnic minorities and to determine whether making such services more culturally responsive would improve the health and thus the longevity of ethnic minority individuals. This kind of information is necessary to design a total strategy for raising the low life expectancy of ethnic minorities.

Using the categories that exist, the data show that "Negro and Other"¹ enrollees use Medicare less frequently than do "Whites" but that when they do use it, they stay in the hospital for longer periods of time and experience a much higher rate of "patient discharges due to death." The implication appears to be that some set of inhibiting factors keeps them away from hospitals until the illness becomes acute enough to overcome the inhibiting factors. The barrier is not likely to be money to pay for medical services since Medicare pays all but the first \$40.00 of the bill.

The results of contacts with community agencies by the ethnic minority consultants during Phase I give an indication of what some of these barriers are. In each

¹While the forms filled out by applicants phrase the ethnic-racial question in terms of "White", and "Negro and Other". The latter terminology is used throughout the rest of this section. (The switchover in categories can be misleading particularly since enrollees classify themselves. Persons who might classify themselves as "Non-White" will not necessarily classify themselves as "Negro and Other".)

ethnic minority community certain points were repeatedly raised:

1. Hospitals are not easily accessible for minority communities.
2. Lack of interpreters and lack of respect for the patients by the deliverers of service because they are poor and/or ethnic minorities, make going to a hospital an extremely humiliating and painful experience.
3. Discriminatorily lower quality of services are given to minority patients.

The problems of insensitive and discriminatory health services can be dealt with. Health facilities certified to participate in the Medicare program, must comply with Title VI of the 1964 Civil Rights Act. The Office of Civil Rights, DHEW, by directing its National Origins Memorandum of May, 1971,¹ towards health facilities receiving Medicare funds, could do much to promote culturally sensitive behavior on the part of such facilities. Since the alternative appears to be the continued less frequent use of Medicare and

¹The National Origins Memorandum refers primarily to equal educational opportunity. Summarized briefly, it asserts that equal educational opportunity must mean a realistic opportunity. a child coming into school speaking little English does not have an opportunity to learn equal to a child whose mother tongue is English, in most schools as presently structured, and that therefore a school has a constitutional obligation to take steps to enable the minority student to have an equal opportunity to learn, in fact, by taking steps such as instituting bilingual/bicultural programs.

the concomitant higher rate of discharge due to death, overcoming the barriers is literally a matter of life and death for elderly minority persons.

Supplementary Medical Insurance (SMI) provides insurance protection for services provided by physicians and other suppliers of medical services. It is available to persons 65 and over who elect this coverage and who pay the monthly premium. 1972 Amendments to the law eliminated previous legislative restrictions which affected the ethnic minorities on time periods within which a person must apply.

During Phase I, extrapolating from the two racial categories used by SSA, it was found that ethnic minorities have a substantially lower rate of enrollment in SMI than does the elderly population as a whole. Approximately 7% of those over 65 nationally are not enrolled for SMI. By contrast, 15% of the aged poor and 11% of the near poor have not signed up for SMI. 22% of the "Negro and Others" were not registered for SMI, a number three times the national rate.

SSA provided SMI usage data on 100 selected counties, in which there was a high concentration of Mexican Americans.¹ In all 100 counties the rate of enrollment of persons over 65 on SMI represented a sharp drop from the national and the relevant state rate of enrollment. No counties could be identified where Puerto Ricans or Asian Americans represented

¹The counties selected for study all had less than 2% Blacks in order to assure that an analysis of "Whites" represented virtually all the Mexican Americans and that there were no Mexican Americans "hidden" in "Negro and "Other Races".

significant numbers. But there is no reason to believe that the problems of poverty isolation, limited English, and low literacy rates affecting Asian American and Puerto Rican elderly should produce a different pattern than that observed for the Mexican Americans and "Negro and Other Races"¹. Evidently a large number of ethnic minority and other minority elderly either are not informed about the benefits under SMI, are not convinced the benefits justify the monthly expense, or could not arrange to apply. Under new SSA policies, all aged on Social Security will automatically become SMI enrollees and have the premiums deducted from their checks unless they return a form indicating their desire not to be covered. This will insure that a greater number of aged persons will be covered by SMI, but still leaves the problem of the elderly not covered by Social Security. (40% of the Spanish Speaking elderly are not covered by Social Security. Statistics on the other groups will not be available until the Special Census reports are issued and analyzed in Phase II.) The Phase II study will seek to complete the data on ethnic minority enrollment in SMI and will begin to explore the reason for the lower enrollment rate.

The data also indicates that those ethnic minorities who are enrolled in SMI are not using it as often as are "Whites", apparently for the same reasons that they are using Hospital Insurance less - the barriers of inaccessible facilities, insensitive delivery of service and lower quality

¹ Indian counties were also studied and revealed a pattern similar to Mexican Americans but they are discussed separately since the impact of the Indian Health Service on health services to elderly Indians produces a different set of problems.

of service. Along with its new policy of automatically enrolling all Social Security recipients unless they signify otherwise, SSA must take the related step of removing barriers to minority utilization of SMI so that ethnic minorities will be able to use SMI benefits as fully as do "Whites". Otherwise while more ethnic minority elderly will be signed up and paying premiums for SMI, they will continue to use the benefits at a lower rate; and the end result of the new policy will be to do little more than take money from the checks of minorities and use it to subsidize medical insurance for "Whites".

The relationship between SMI and Reservation Indians presents a good example of the need for all of DHEW to be sensitive to differences among the various ethnic minorities. Because reservation Indians are served by the Indian Health Service, they have little occasion to use SMI. Yet during the initial SMI sign-up, SSA signed up a large number of reservation Indians. The SMI premium is deducted from their monthly Social Security check yet they rarely use the benefit because of the services available from IHS and because non-IHS health facilities are usually geographically inaccessible to them. As a result the amount of benefits expended per enrollee under SMI (based on counties with reservations) for Indians is the lowest for any group in the country. In some areas, the average benefit is less than one month's premium. While SSA is now informing new Indian Social Security recipients about the overlap, it apparently has not informed those who are already enrolled, and it continues to deduct the premiums from their checks.¹

¹Telephone conversation with SSA office. Farmington, New Mexico Jan. 22, 1973.

In addition to informing Indians already enrolled of the overlap, the new SMI enrollment policy, which automatically deducts SMI payments from Social Security checks (unless a form indicating otherwise is returned), should be adjusted to take into account the particular situation of Reservation Indians. Otherwise many may end up paying for something they don't need, just because they failed to return a form. Given the poverty on the reservations, these elderly Indians can ill-afford to forego needlessly \$5 - \$6 of their monthly Social Security checks.

Medicare was instituted to improve the quality of health care for elderly Americans. But the only tool given it with which to do so, was money. Medicare is basically a voucher system. Almost all it can do is pay bills. The fact that there are barriers, in addition to the lack of money, in the way of quality health care for at least some Americans was not recognized in the original planning of Medicare, which now makes it very difficult for Medicare to deal with the type of problems and barriers experienced by ethnic minorities. Phase II will define the problem further and develop legislative recommendations or guidelines to attempt to solve them.

III. D. Maternal and Child Health

Formula grants for Maternal and Child Health Services (MCHS) are designed to provide financial support to states to extend and improve services for reducing infant mortality and improving the health of mothers and children. Emphasis is placed on rural areas and in areas suffering from severe economic distress. Matching grants are made to state health agencies on a formula basis and may be used for services in maternity clinics, school health programs, family planning, and training of professional personnel. Funds may not be used for construction of facilities.

The Phase I study was unable to even begin to evaluate MCHS's delivery of services to ethnic minorities. HSMHA had almost no relevant information on the performance and accomplishments of the program as a whole, much less on its services to the ethnic minority. Evaluative studies of MCHS by Macro Systems, Inc., have concluded that the absence of information results from inadequate accounting and reporting by the states to DHEW on their use of the MCHS formula grant funds. They further found that states rarely followed the Federal guidelines for reporting formula grant expenditures and, by failing to do so, avoided providing MCHS with any usable information on expenditures or performance. Behind this inadequate reporting by the states, Macro Systems found evidence of intentional diversion of MCHS funds for purposes not provided in the legislation and the regulations. In many states "...the funds are distributed within

the states in the form of block grants to county and municipal health departments; and it is common knowledge that many of the funds eventually are used for general administration of county and municipal health departments and for salaries of personnel only partly if at all, providing maternal and child health services."¹

In addition to inaccurate reporting by states and diversion of funds, Maternal and Child Health Services failed to monitor the state program and enforce its regulations. Since ethnic minorities experience the highest infant mortality rates and are thus among the intended beneficiaries of the Act, the breakdown of the reporting system and the diversion of funds effectively denies them health services which they desperately need and which are rightfully theirs.

Macro Systems reported that the existing system of reporting is scheduled to be discontinued at the end of the current fiscal year, and no replacement is contemplated. If DHEW wishes to protect the interests of minorities and the legislated purposes of the Act rather than eliminate the system, it would have to develop and institute an effective system of program monitoring and fiscal accountability for Maternal and Child Health Services in lieu of the current ineffective system and take vigorous steps to place its own house in order in terms of enforcing its own regulations and guidelines.

¹Memorandum on Legislative Options Relative to Title V of the Social Security Act, prepared by Macro Systems for DHEW, November 2, 1971, p8

III. E. Community Health Centers

Community Health Centers with different emphases are funded under a variety of legislative sources. Several Centers have project grants from several different DHEW programs providing a variety of services to its consumers.

The programs include:

1. 314(e) Partnership for Health

The purpose of the 314(e) program is to support a full range of public health services to meet special needs at a community level, especially the development of comprehensive health centers for populations not otherwise being adequately served by other health services programs.

2. Maternity and Infant Care Projects

Maternity and Infant Care Projects provide services designed to reduce the incidence of infant and maternal mortality, and of mental retardation and other handicapping conditions associated with child bearing. Emphasis is on the provision of care for "high risk" infants. Intended beneficiaries are low income mothers and infants subject to conditions that increase the hazards surrounding pre- and post-natal care.

3. Health Care for Children and Youth (C&YC)

Children and Youth Centers provide comprehensive health care and services for children in low income areas.

4. Dental Care Projects

Dental care projects are designed to promote the dental health of low income children and youth of school or pre-school age.

5. Family Planning Projects (FPP)

Family Planning Projects provides educational, medical, and social services necessary to enable individuals to freely determine the number and spacing of their children. Priority is given to low income families. Services include contraceptive advice and the provision of contraceptive supplies on a continuous basis.

6. Regional Medical Programs

Regional Medical Programs support regional cooperative arrangements in the field of health designed to improve health services for persons residing in areas with limited health services.

7. Family Health Centers

Family Health Centers develop and provide health maintenance and treatment services in areas with

scarce health services on a prepaid health maintenance basis to the enrolled population. Funds may also be used to pay for services for low income enrollees.

Several of the Community Health Centers have been compiling extensive data. The initial results indicate that Community Health Centers are succeeding in providing meaningful health care to poverty communities including some ethnic minorities. Several Centers are funded under different program sources and it is therefore difficult to separate programmatic impact by funding source. Individual centers serve Indians, Puerto Ricans, Mexican-Americans and several serve multi-ethnic populations. With the high incidence of disease among ethnic minorities, there is a need to continue and expand these programs.

Funds for Family Planning Centers have not been made available specifically to American-Indians, Filipinos or Chinese although they have continuing high birth rates.

The expenditure of \$92 million on Maternal and Child Health Centers (project grants) has materially reduced maternal and infant death rates, and the incidence of disease among children and, once operating (beyond a development period), has reduced the per patient cost of service. These programs provide service to Mexican-Americans, American Indians, and Puerto Rican children. (Clear evidence that Asian Americans are being served is available in only one multi-ethnic program at Gouverneur Hospital in New York City.)

When the Maternal and Child Health funds were to revert from a project grant structure to a formula grant structure, the project grant program was extended for one year because of their high degree of success. However, the prospect is that the Maternal and Child Health project grants are likely to lose their authorization at the end of FY 73. The Macro, Inc. study indicates that most states in which MCHS Centers exist will not have the funds available to keep them operating.

The 1971 DHEW Annual report suggests that "The Comprehensive Health Centers have afforded many individuals the opportunity to participate in planning, development and operation at localized health services." However, State Health Planning Agencies or Areawide Health Planning Agencies are given the authority to identify and select "health service scarcity areas" which takes out of the hands of the citizens the first and primary decision as to who would be served. In a study of consumer participation in the eight community health center programs in various levels of HSMHA's service projects,¹ Community Change, Inc. found that regulations and guidelines affecting community participation were frequently not issued by HSMHA. Only two of the eight HSMHA service programs, under which a variety of Community Health Centers operate, have produced regulations making consumer participation mandatory. Three of the eight have issued no regulations at all. Further, only 22% of the programs have consumer members on governing boards; 40% have consumers in advisory roles;

¹Precis on an Evaluation Study of Community Participation in Eight Community Health Centers, prepared by Community Change, Inc., for DHEW, Sept. 1972

37% have no structurally guaranteed participation, although several programs have legislative or regulatory requirement for such participation. Project site visits suggested that the actual level of consumer influence over decision-making was even less than the data indicated. However, in terms of legal compliance, due to the vagueness of most HSMA policies on community participation, most of the projects were technically in compliance.

Although supposedly committed to community participation, DHEW issued regulations for Family Health Center projects on March 31, 1972, which literally say that public participation in development of regulations will be bypassed.

III. F. Vocational Education

The Vocational Education program consists of eleven different components - the primary Basic Grants to States plus ten specialized programs which build on the primary one. The Basic Grant Program to States is designed "...to assist in conducting vocational programs for persons of all ages in all communities who desire or need education and training for career vocations." Funds are available for the construction of vocational education facilities, counseling, training, development of instructional materials, and administration. Funding is on a formula grant basis. To be eligible, a state must establish a State Advisory Council and submit a State Plan. Fifteen percent of a state's total allotment must be set aside for vocational education for the "disadvantaged."

As the legislation and guidelines are written, a major direction of the Vocational Education Program is for specialized services to ethnic minorities. The 15% set-aside for the disadvantaged is above and beyond funds to be spent on disadvantaged students as part of the regular Vocational Education programs and is to be used only for supplemental services to the disadvantaged. According to the Guidelines, "...only those funds expended for the disadvantaged or handicapped student to help him succeed in the regular vocational education program shall be charged to the disadvantaged or handicapped set-aside funds."

The definition of "disadvantaged" contained in the program guidelines and regulations clearly emphasize many of the difficulties unique to ethnic minority individuals, in defining "disadvantaged" and in spelling out the services to be provided to them under the 15% set-aside provisions. These guidelines and regulations are reflected in the State Plans. The Colorado Plan includes in its definition of academically disadvantaged "Language deficiency...English as a secondary language." The California State Plan speaks of "...linguistic difficulties, racial and ethnic composition." Yet despite the clear intent in legislation, guidelines and State Plans to serve the particular needs of ethnic minorities in Vocational Education Programs under the 15% set-aside provisions, the evidence indicates a gross absence of culturally relevant curricula necessary for effective programming for many ethnic minority individuals; little indication of special planning for ethnic individuals; and indications that ethnic individuals are not receiving their fair share of services under the program.

It is difficult to determine the extent of services provided to ethnic minorities under the Vocational Education Programs. Data collected by Vocational Education is broken down into only two statistical categories: "Black" and "All Others." Indians, Asian Americans and Spanish Speaking are lumped in with Whites. The same is true in the allocation process. While the "Black" and "All Others" designations utilized by Vocational Education permit specific allocation of funds for Black programs, no comparable allocation process

is made for ethnic minorities under the existing structure. Preliminary examination of existing information conducted during Phase I indicates that this lack of information on services to ethnic minorities within Vocational Education, serves to mask a manifest lack of Vocational Education services to them, specifically under the 15% set-aside provisions.

Data in the Congressional Record shows the percentage of ethnic minorities in all Vocational Education programs as follows: Spanish Speaking, 4%; Indians, 3%; Asian Americans, 0.5%.¹ This in no way reflects the 15% disadvantaged set-aside, the special disadvantaged component, and most importantly, the very high percentage of ethnic minorities in the population in need of Vocational Education services. Since the 15% set-aside represents a substantial sum of program dollars - \$29,890,000 in 1972, and since ethnic minority individuals represent a high percentage of the disadvantaged population as defined (since they have a lower college attendance rate, a higher drop-out rate, and a higher proportion in the "youth" population), it would appear that they are receiving far less than their fair share of service as funds are allocated under the Vocational Education Act.

¹Congressional Record. June 18, 1971

1. Misuse of 15% Set-Aside Funds

In a GAO study of four states¹ (California, Michigan, Ohio, and Pennsylvania), evaluators found that a significant portion of the funds allocated for the disadvantaged was used for persons who did not fit the criteria of need for special programs. Persons participating in the program were not necessarily disadvantaged and often the programs were part of, and indistinguishable from, the regular Vocational Education Program.

An examination of the proposals funded for curriculum development projects in Vocational and Technical Education for FY '72 suggests that of the \$3,999,660 allocated to such projects, only \$243,813 was funded to projects which were directly pertinent to ethnic minorities. This sum of money covers only three projects, and only two of them - "Developing Career Awareness for Spanish Surnamed People" and "State of the Art Paper on Curriculum Development for Occupational Education of Indians" - totaling \$44,731, are likely to be involved with considerations of language or cultural diversity of the particular ethnic minority.

There is an almost total absence of bilingual curriculum material in any of the Non-English languages utilized by the ethnic minorities. There is no evidence of bilingual

¹Training America's Labor Force: The Unfulfilled Promise of Vocational Education, General Accounting Office. The Comptroller General Of the United States, 1972

curriculum or instruction in the basic education portion of the Vocational Education program. Yet basic education, the ability to read and write, is the key to successful technical training. Nor does there appear to be a recognition of the bicultural problems faced by ethnic minorities which often seriously impair their utilization of vocational education to achieve occupational success. Until funds are spent for these essential purposes, the Vocational Education Program cannot be fully responsive to the ethnic minorities or to its own regulations and guidelines.

The Bureau of Adult Vocational and Technical Education (BAVTE) has recently tried to deal with some of these problems by conducting a training conference for the purpose of training teachers in techniques for adapting existing curriculum for use with the disadvantaged. How much focus was placed on the ethnic disadvantaged is not known; however, curriculum development for the ethnic minorities must be a full-time undertaking, adequately funded and performed by those who are technically skilled for the purpose. Also, no amount of ad hoc training conferences can ever replace a rational and comprehensive plan designed specifically to meet the needs of the ethnic disadvantaged.

2. Employment In State Departments of Vocational Education

Perhaps one reason for the unresponsiveness of Vocational Education Programs to the ethnic minorities is the lack of ethnic minority employees in state offices of Vocational Education. Available data portrayed the following employment picture:¹

Employment by Ethnic Group in State Office of Vocational Education In:

(The figures in parenthesis are the per cent of that ethnic group in the total population of the state.)

Illinois

White - 91%
Black - 9%
Spanish Speaking - 0% (3.5%)

Colorado

White - 86%
Black - 14%
Spanish Speaking - 0% (13%)

California

White - 83%
Black - 12%
Spanish Speaking - 4% (15.5%)
Asian American - 1% (3%)

Oklahoma

White - 100%
Black - 0% (7%)
Indian - 0% (4%)

3. Community Participation In Planning Process

Another possible explanation is the failure to implement and use the community participation mechanisms available in the Vocational Education Program.

a. Advisory Councils

The legislation requires membership on Advisory Councils to be comprised of persons who are:

representative of the general public, including a person or persons representative of and knowledgeable about the poor and disadvantaged, who are not qualified for membership under any of the preceding clauses of this paragraph.

¹

Response to questionnaires sent to State Offices of Vocational Education of the Selected states (See Introduction for list of selected states.) for the Phase I study.

Yet, on the basis of the Councils reviewed, as presently constituted there are virtually no individuals represented from the ethnic minority community who are not strongly identified with, and frequently employed by Departments of Vocational Education.

b. Public Hearings

Vocational Education legislation requires public hearings on State Plans, to which there is supposed to be community access. Illinois provides a case in point. At a public hearing held in May, 1972, at Bloomington, Illinois on the State Vocational Education Plan, only thirty-five people attended. The "public" who testified at the hearing consisted of: five Vocational Agriculture teachers who testified on extending and maintaining vocational agriculture, a proposal to fund a Work Study program in the state by a Cooperative Education teacher, and testimony in support of career education by a businessman. No significant positive variations from this pattern elsewhere in the country were found in Phase I.

1

State Plan For Vocational Education, State of Illinois, 1971

Although a subtle distinction, the point here is not that the interests of the ethnic minorities have been deliberately excluded, but rather that such "standard" mechanisms as public hearings and state plans do not necessarily assure that the interests of the ethnic minorities will be effectively represented. Indeed, the single most consistent finding throughout the whole of Phase I is that in the absence of mechanisms specifically designed to protect and assert the interests of the ethnic minorities, the system is virtually always, and will continue to be, unresponsive.

4. Accountability And Monitoring

One of the most serious causes of non-responsiveness of the Vocational Education Program to ethnic minorities is the absence of sound accountability mechanisms and monitoring procedures.

a. The State Plan

The State Plan is an inadequate tool for assuring that the legislative concern for the specific needs of ethnic minorities is translated into effective action. Though rigidly structured and meticulously detailed according to the DHEW specifications, examination of the State Plan for the six selected States in the Phase I study did not reveal the kind of data necessary to evaluate performance by State Vocational Education Programs to determine whether adequate services were being offered to the disadvantaged, particularly to ethnic minorities.

b. Non-Enforcement

Even if the necessary data were available, indications are that DHEW would not act on it. Discussions with BAVTE staff indicated a belief that it was inappropriate for the National office to be intrusive with the states in monitoring their programs. Instead, "informal" processes are relied on. The attitude that the Federal government should not be intrusive with the states who administer billions of dollars in Federal funds, supposedly in compliance with Federal laws and Federal guidelines, may prove to be the single greatest barrier to the realization of fair share of culturally relevant services by the ethnic minorities.

III. G. Bilingual Education - Title VII, ESEA

The Bilingual Education Program is designed to develop bilingual education programs to meet the special needs of children 3 to 18 years of age who have limited English speaking ability; who come from environments where the dominant language¹ is not English; and who are enrolled in schools having high concentrations of children from families whose earnings are below the poverty line. Grantees are primarily local educational agencies, but a non-profit institution or organization of an Indian tribe may be eligible when it operates a school on a reservation.

Title VII was originally designed as a demonstration program. The Title VII Manual states, "Title VII, ESEA funds are available for exemplary pilot or demonstration projects in bilingual and bicultural education in a wide variety of settings. These projects should demonstrate how bilingual education can improve the general educational program."²And, in effect, it has been a demonstration project. Based on information provided by the Title VII Office, Title VII is serving approximately 50,000 children, or about 1% of the five million children the Office of Education estimates are eligible for Bilingual Education.

The purpose of the pilot programs was to introduce school districts to the educational benefits of bilingual/bicultural programs, and, as specified in the regulations,

¹45CFR 1, Part 123.1 Definitions. (f) "Dominant language" means, with respect to a child, the language commonly used in the child's home or community.

²1971 Manual, p.5

encourage school districts to expend an increased amount of funds from other sources, "including funds made available under Title I of the Act",¹ on bilingual/bicultural programs. But, in fact, this has rarely happened. Apparently just the existence of Title VII (not necessarily the availability of funds) puts a damper on the use of Title I for bilingual purposes. The reasoning seems to be that since ethnic minorities have their own program (Title VII), there is no need to use Title I funds for specialized programs for them.

If there were anywhere near a sufficient amount of Title VII money available to serve ethnic minorities, this reasoning would not be so damaging. But in view of the original design of Title VII as a demonstration project, and the vastly greater proportion of funds available through Title I², the actual result of the existence of Title VII (at current levels of funding) may be to cause a net decrease in the amount of funds actually committed to bilingual and bicultural programming by using Title VII to provide an excuse not to use Title I funds for these purposes.

1. Allocation

Title VII funds do not seem to have been allocated

¹45CFR 1, Part 123.5 (f)

²In 1972, the Spanish Speaking received \$22 million from Title VII but \$3,213,000 from Title I; Asian Americans received \$217,000 from Title VII but \$3,213,000 from Title I; and the American Indians received \$1.3 million from Title VII but \$21,100,000 from Title I.

among the different minority groups on any seemingly rational basis. Allocations do not seem to be made on the basis of population. Of the 196 programs funded in 1972, 168 were funded for the Spanish Speaking, 3 for Asian Americans (Chinese), 17 for Indians and the remainder French and Portuguese.

The low level of funding for Asian Americans also indicates that allocations are not based on that percent of each ethnic population group which is non-English speaking. Since 1966 approximately 143,500 Filipinos, 60,000 Koreans, and 108,000 Chinese entered this country; 80% to 90% who have entered do not speak English, making Asian Americans the fastest growing non-English speaking population in the country. There have been no bilingual programs funded for Filipinos or Koreans and only three for Chinese. Data that reflects changes in ethnic populations are needed to keep the Office of Education aware of these trends. Where no proposals are submitted for programs for Koreans and other groups with rapidly increasing numbers of non-English speaking children, OE could actively solicit them now so as to not be faced with a more massive problem in the future.

A Filipino Title VII proposal was submitted to OE by the San Francisco Unified School District in 1972. It was turned down on the grounds that the priority was to fund school districts that have never received Title VII funds before - which ruled out the San Francisco District.¹

¹Information received from the Office of Asian American Affairs, OSC, DHEW.

The logic behind this system of priorities is not at all clear, and it definitely serves to discriminate against the different Asian American subgroups which tend to congregate in the large California cities, that also have large Spanish Speaking populations. San Francisco as the most polyglot city in the United States is most disfavored by such a decision. In addition, a program developed for Spanish Speaking, or Chinese does not demonstrate an appropriate bicultural (or for that matter bilingual) program for Filipinos.

The cost of bilingual programs varies from group to group. Many Indian languages have never been written. A bilingual program for a tribe may have to start with the basic task of putting the language into written form and then putting together the first books written in that language. If this is to be effective, the curricula cannot be a carbon copy of "White" curricula, but should reflect the Indian's different motivational and learning patterns. All these factors make preparation of an Indian bilingual program much more expensive. The allocation procedure should reflect these realities.

The target population of Title VII is children from 3 to 18 years of age. All of the projects reviewed during Phase I, however, involved only grade school participants. There is great need for development of programs for other than elementary school children. Such programs, in addition to serving the specific populations, could add significantly to the basic knowledge and versatility of

bilingual skills. Programs for older children would also have a broad range of other uses - such as in adult education and vocational education programs.

Similarly the development of bilingual programs for pre-school children could obtain dramatic results, since children develop language skills most rapidly and with relative ease at this age.¹ Nor were any bilingual vocational education programs funded, despite the fact that the Act lists "...programs conducted by accredited trade, vocational, or technical schools;"² as one of the suggested areas of activities for Title VII bilingual/bicultural programs. In addition, vocational education is of particular importance to ethnic minorities who have more limited opportunities to obtain higher education. If Title VII is to be a demonstration project to "stimulate and promote the development and operation of new imaginative...programs",³ it should be funding a wider variety of programs in order to stimulate bilingual/bicultural programs in the whole range of educational services that are important to ethnic minorities.

2. Program Deficiencies

The material analyzed in Phase I also indicates operation of Title VII programs could be considerably improved. In spite of specific regulations requiring that the "dominant

¹The Act specifically refers to "(4) early childhood educational programs related to the purposes of this title and designed to improve the potential for profitable learning activities by children"; 20USC 880b-2(c)(4).

²20USC 880b-2(c)(7)

³45CFR 123.4

language" be used for instruction during part of the day, only half the Title VII projects reported by a PEBSI study were in accord with this requirement.¹

Cultural material utilized often revolve around marginal issues such as holidays and artifacts, rather than on the rich and significant cultural values, characteristics and history of a group.²

In funding bilingual projects, only a beginning has been made. There is a need to focus on what goes on in the courses and the support required to establish the programs, as well as assuring that funding is available for the courses themselves.

These program deficiencies underline a more basic deficiency - the acute shortage of teachers with bilingual skills. Greater emphasis has to be made of the various educational student assistance and training programs to produce more ethnic minority teachers and paraprofessionals capable of teaching these courses.

However, there is an even more important issue from the point of view of the ethnic minorities. Bilingual/bicultural programs are not simply just devices to get ethnic minority children to achieve better in school. They are essential to the very survival and perpetuation of the ethnic culture and values and thereby essential to their self-respect, and the right to choose their way of life.

¹Bilingual/Bicultural Education Program Report, PEBSI, The
BLK Group Inc. November 1971.
²Ibid

A bilingual program can turn ethnic cultural characteristics from "deficiencies" or "barriers" which have to be eliminated or overcome, to sources of pride and self-respect. In this context, a child no longer has to choose between retaining his culture or succeeding in American society. For ethnic minority children, bilingual/bicultural programs are the start to making this right an actuality. However, a program, that reaches only 1% of those who need such services - offers much promise and little hope.

III. H. Educationally Deprived Children - Title I, Part A ESEA

Title I, Part A, ESEA, is designed to expand and improve educational programs to meet the needs of educationally disadvantaged children in low income areas. It includes such instructional and service activities as: remedial reading and math, food, health, psychological services, and cultural development, among others. The Act provided that services must supplement, not supplant, those normally provided by state and local educational agencies. Funds are allocated on the basis of the number of children 5 through 17 years of age in:

1. Families having an income below \$4,000 a year;
2. Families receiving AFDC;
3. Foster homes and institutions.

Money is allocated to a state which in turn distributes a fixed amount to LEA's within each county on the basis of proposals submitted by the different Local Educational Agencies within the county. The problems of misuse of funds have been known for 7 years in the largest education program operated by OE; yet little real pressure has been placed on the local school districts that have continued year after year to misspend funds in the same way.

The legislation, regulations, and guidelines for assistance require that areas having a high concentration of low income

families be selected first,¹ that parents of the children to be served are consulted in the planning of the project, and that projects be designed to serve those having the greatest need for assistance.² Title I funds are not to be used as a general aid to the school systems.³ They are not intended as general aid to SEA's, LEA's, or schools in general, or even to all children in a target school. A review of the reported violations of regulations and guidelines indicates that all of these requirements are being ignored.

Violation of regulations deny poor children their legislated benefits. Since ethnic minority children are disproportionately present among poor children, a larger number proportionately of ethnic minority children are being denied their rights under this legislation. The Guidelines propose that children should receive a variety of services - most receive only one service. The per pupil allocation of Title I funds should equal one-half the state and local allocation, but the figures indicate the spending is closer to one-fifth.⁴

The 1972 Annual Report of the National Advisory Council for Educationally Disadvantaged Children describes the newest effort to bring Title I money into line with legislation:

Comparability is a new regulation about which States have been advised for well over a year. Comparability requires that all sources of monies which result in the total per pupil expenditure before Title I funds are added be equalized in the school district, so that each student receives the same per pupil expenditure. Only after this has been accomplished can Title I funds be added for Title I - eligible children, to contribute effectively to a true compensatory education program.

¹45 CFR 116.17 (a)(d).

²45 CFR 116.17 (f).

³45 CFR 116.17 (g). Also Title I Program Guide 334.

⁴American Institutes for Research, ESEA Title I: A Reanalysis and Synthesis of Evaluation Data from Fiscal Year 1965 through 1970, March, 1972.

This concept is an extension of the early regulations, which state that Title I monies are to "supplement and not supplant" local expenditures. Simply stated, this means that Title I is designed to be "something extra" for educationally disadvantaged children.

Comparability went into effect July 1, 1972. A DHEW Audit reveals that only one in 80 of the nation's largest cities complied fully with the law. Local authorities do not keep records school by school; states accepted clearly insufficient reports and lacked any plan for systematic checking, although new guidelines were prepared by DHEW setting up a system for accumulating the data. The report states, "In addition, monitoring by the Office of Education was not effective," and continues, "Our review also indicates that most state education agencies lack any effective plan for monitoring comparability... In many cases not even a cursory review of local agency reports was evidenced."

The end result of no accountability is no service. The NACEDC's investigation in 1968 indicated that about one-quarter of the programs operating at that time were bringing results. In 1972 their estimate is that more than one-third of the Title I programs are facilitating the education of disadvantaged children - certainly an improvement but not enough when we remember that "Two-thirds of Title I eligible students are unserved; and many more poor children, whose parents gross more than \$2,000 - \$3,000 annually are not even ineligible."¹

¹1971 Annual Report of National Advisory Council for Educationally Disadvantaged Children (NACED). Although Congress legislatively permits children in families with incomes of \$4,000 to qualify, appropriations have not been raised to serve them.

III. I. Rehabilitation Services Administration

Vocational Rehabilitation is a program of the Rehabilitation Services Administration (RSA) created to assist persons with mental, emotional, or physical handicaps become gainfully employed. The services it provides include diagnoses, evaluation, medical treatment, counseling, training, income maintenance during rehabilitation, and placement. The program is funded through designated state agencies on a formula basis - population weighted by per capita income squared.

1. State Plans

The states report to RSA through the State Plan. The Phase I review found that the Plans are worthless in terms of discovering what the state agencies are actually doing and, in particular, what they are doing vis-a-vis ethnic minorities. The plans are merely reaffirmations of the 1966 plans which are kept in RSA's office, virtually unchanged since 1966, as "assurance" of the state's intention for FY 72. There are no statements as to where District or Area Offices are, or who are to be served by them except in the most general terms as provided for in the Manual. State plans literally copy verbatim whole passages from the Federal Manual, indicating that at a functional level, the state "plan" is hardly a plan which influences program operations, but is more a rote response to a bureaucratic requirement. No functional knowledge of the program could be obtained from the review of the state plans. The plans are so broad and without substance and detail, there was no way to differentiate the program from state to state - from Oklahoma to California.

No functional accountability could be maintained on the part of the Federal government or the state since there is no clear plan of operation or performance objectives against which to monitor the program. Since the state itself operates the formula grant program at the local level, monitoring done by the state is a case of the state monitoring itself.

Data from the 1970 Census indicates that ethnic minorities have a substantial need for rehabilitation services.

The Spanish Speaking have a somewhat higher percentage of their population disabled than do Whites; 11.5% for Spanish Speaking; 10.8% for Whites; 15% for Blacks. (Data on Indians and Asian Americans are not yet available.) Spanish Speaking persons who are disabled have a lower percentage of the disabled in the labor force and a higher percentage listed as disabled who cannot work.¹ Both these factors are often a product of lack of rehabilitation services which, were they available, would permit some of those who "cannot work" to return to the labor force. There is an additional 14% who are neither classified as "in the labor force" nor "cannot work" who potentially could enter the labor force were rehabilitation services available.

RSA does not keep detailed beneficiary or service data on ethnic minorities. The only ethnic data that could be found

¹1970 U.S. Census of Population, U.S. Summary. General Social and Economic Characteristics Table 89

was a single chart on percentage of ethnic minorities in the RSA client population.¹ The chart shows the percentage of ethnic minorities in RSA's client population as just about the same as the percentage of ethnic minorities in the general population. Since RSA's regulations mandate concentration on the disabled in the poverty population, and since ethnic minorities constitute a considerable percentage of the population in poverty, the percentages given in the chart indicate that ethnic minorities are being underserved. The Chart is also suspect as a reliable source of information since RSA does not routinely collect data by ethnic group and no one interviewed in RSA could determine where the information on the chart came from.

While there is no detailed information on how the ethnic minority disabled are being served, RSA does maintain detailed

¹Beneficiary Data Reported by Rehabilitation Service Agency
by Race, 1970

<u>Characteristics</u>		<u>Percent</u>
<u>Race:</u>		
White		78.5
Negro		20.1
Indian		0.5
Other		0.9
<u>Surname:</u>		
Clients with Spanish Surname		4.3
Clients without Spanish Surname		95.7

¹ data on Blacks. RSA spends substantially less per client on its Black clients than on "All Other" clients for every type of service it provides. This is particularly noticeable for those service categories in which the decision as to how much to spend per client is left completely to the discretion of the counselor. For example RSA spent an average of 32% less on Other Services, (e.g. transportation and other necessities in addition to training and maintenance costs) for Blacks than it did for "All Others." While such detailed data is not available for the ethnic minorities, PEBSI evaluations of individual programs which serve ethnic minorities found the same lower level of service and expenditures for ethnic minority disabled.² For example, a PEBSI evaluation of the Vocational Rehabilitation Department serving the Crow Indian Reservation in Montana found, that the funds expended for Indians were 85% of that expended for Whites in the area, and that Indians were not provided with funds for transportation.³

¹ Cost of Services Provided Negroes as a Percent of Cost of Services Provided All Other Clients

Mean costs (for clients on whom agencies incurred a cost)

Type of service	Negro Clients	All Other Clients
All services	\$537	\$695
Diagnostic procedures	75	94
Restoration	414	455
Training and materials	586	733
Maintenance, etc.	322	420
Training allowances	242	328
Other services	227	346

²Vocational Rehabilitation Program Report, PEBSI, The BLK Group Inc. November 1971.

³Ibid.

Information such as this can only support an assumption that, in this program as elsewhere, apparently discriminatory patterns repeat themselves, and where Blacks receive less than Whites, so also ethnic minorities receive less than Whites. Other findings of the PEBSI evaluations also support this assumption.

Problems indicated by PEBSI consumer evaluations of rehabilitation services received by ethnic minorities include the fact that District and area offices are frequently poorly placed to serve an ethnic minority clientele. Responsibility for appointments and follow-up is placed on the client. Tardiness for appointments was viewed with great disfavor by counselors. Such policies and practices are particularly difficult for Indians living on reservations without a telephone, who are also contending with poor transportation and great distances. Acceding to the demands of counselors is also particularly difficult for any client without facility in English.

According to PEBSI evaluators, the client, in training had to lay out funds for books and supplies and was not reimbursed for a month. For the many disabled, with very low income, this could be an insurmountable barrier causing clients to drop out of the program. PEBSI further reported that 90% of the White clients served did not meet the financial need criteria.

The evaluations also reported that the economically disadvantaged are usually labeled as suffering from a psychological or mental handicap to justify their eligibility for rehabilitation services, although this stigmatization usually is not necessary in cases where physical and defined social disabilities exist.

Family involvement is required by national guidelines but is nowhere reflected in any of the PEBSI evaluations reviewed. PEBSI also reported, in the case of the Vocational Rehabilitation Department serving the Crow Reservation:

"There is no advisory group, and the Vocational Rehabilitation Department does not actively solicit any sort of dialogue with the consumer population for suggestions about improving itself. There is no effort at community education about the program, nor any effort expended to aid the non-Indian staff to better understand their Indian Clientele."

Several studies have documented Vocational Rehabilitation's insensitivity to the cultural characteristics of their clients. A National Rehabilitation Association study in 1970 concluded:

"Furthermore, the existing Anglo counselors... cannot converse in Spanish, and understand the culture only in terms of stereotypes...the services lacked cultural sensitivity since there were almost no ethnic staff at the local level."

RSA nationwide employs no American Indian or Asian American at any level and no Spanish Speaking staff at the policy making level (GS-13 or above).

The Phase I analysis of the Vocational Rehabilitation program indicates that the availability of additional beneficiary data is essential to determine precisely the service received by ethnic minorities. The absence of ethnic minority staff at all levels and the wholesale lack of responsible culturally sensitive program planning related to the special needs of the ethnic minorities warrants further investigation.

¹Vocational Rehabilitation Program Report, PEBSI, The BLK Group, Inc. November 1971.

III. Head Start

The Head Start Program is designed to provide educational, nutritional and social services to pre-school children of the poor and their families and to involve parents in activities with their children, for the purpose of enabling the child to enter school on more equal terms with his less deprived classmates. 90% of all enrollees in a Head Start program must come from families whose income is below the poverty guidelines. Programs are funded to local Community Action Agencies (CAA). Where no CAA exists, certain public or private non-profit agencies are eligible.

In a number of areas, Head Start is exemplary in the provision of culturally responsive services to ethnic minorities.

1. Data

Head Start collects data by ethnic origin for staff, children, and parent advisory councils. Although the program is making a valiant effort to accumulate beneficiary data nationally, this has proven somewhat difficult since not all program data has been recorded in a standardized manner. However, progress is being made.

2. Community Participation

Head Start provides for 100% parent committees for each Head Start Center, and at least 50% parents on Head Start Policy Committees and Policy Councils. This seems to be the case in fact as well as in program guidelines, providing parents extensive involvement in their children's education at many levels including selection of center directors, review of the curricula, etc.

3. Ethnic Composition of Beneficiaries

Head Start is effectively bringing ethnic minority beneficiaries into its programs. In fact, the percent of ethnic minority children in Head Start is frequently greater than the percent of ethnic minorities in the general poverty population. They are not being overserved, however, because ethnic minorities have larger families and more young children than do the rest of the disadvantaged population. To get an accurate measurement, then, one must compare the percent of ethnic minority children in Head Start against the percent of ethnic minority 3 and 4 year olds in the general poverty population of 3 and 4 year olds. In Phase I, we used this measure in a study of Head Start in 22 selected communities. We found that Mexican American, Puerto Rican and American Indian children were being served in proportion to their numbers. Asian American children, however, were underserved in all but 3 of the 22 communities.

4. Head Start As An Exemplary Program

Head Start is most closely exemplary of all the DHEW programs investigated during Phase I of the study insofar as the ethnic minorities are concerned. The program has a high degree of community and consumer participation at all levels - program planning, monitoring and evaluation, and has considerable consumer participation in the actual delivery of services, resulting in a high degree of "cultural relevance" at all levels. Perhaps this is a major reason why Head Start alone, of the

programs investigated during Phase I, serves the ethnic minorities in fair share proportion to their needs at all levels, with the exception of the Asian Americans.

Not only does the program have carefully devised guidelines which do reflect bilingual and bicultural considerations so crucial to the delivery of effective services to ethnic minorities but, even more unusual, is the degree to which program guidelines are adhered to as a matter of course. Relatedly, the Office of Child Development assumes a mandate for encouraging adherence to program guidelines.

In addition, although not a perfect system, the Management Information Systems (MIS) employed by Head Start is designed in a manner to yield a large body of data which relate directly to the program objectives and emphases contained in the program guidelines, including many data categories which reflect a sensitivity to considerations unique to the ethnic minorities.

In all of Phase I, Head Start has proven to be a programmatic anachronism - in the most positive sense of the word. It could well serve as a model in redesigning other DHEW programs in order to make them more relevant to the needs of the ethnic minorities.

IV. ISSUES

A. Overview

The Issues Section presents a compilation of findings and impressions drawn from the ethnic profiles and analyses of the particular programs studied during Phase I. The Issues Section is divided into seven sub-sections, each representing a major problem area impacting most, if not all, of the programs studied in Phase I and all of which were found to have particularly significant implications for ethnic minority individuals in need of DHEW programs and services.

The explication of each of the seven problem areas is not presented as an exhaustive analysis of the subject or as having identified the "ultimate causes" of barriers to the provision of quality fair share services to the ethnic minorities. While it was possible to identify specific barriers to effective service, it was not so possible to clearly distinguish cause from effect. Thus Phase I, as a four month survey of the extent of delivery of culturally sensitive services to the ethnic minorities and identification of the major problems which inhibit that objective, did not permit exhaustive analyses and particularly did not permit exploration into the definitive "causes" of the problems which were identified. Therefore no integrated comprehensive statement of the "causes" of deficient service has developed in Phase I. These seven major problem areas identified in the Issues section are intended to provide a useful perspective for approaching and evaluating the range of problems that were found to exist in the delivery of services by DHEW to ethnic minorities, and some of the ways those problems relate to each other.

IV. B. Ethnic And Bicultural Considerations

The Phase I study found that a basic resource needed by program planners and administrators to enable them to improve the delivery of culturally sensitive services to ethnic minorities is a deeper understanding of who the ethnic minority individuals are and the implications of their cultural orientation and life style for the planning and delivery of services. As it has been necessary to learn the characteristics of poverty and the restraints they impose on an effective delivery system, a similar lesson has to be learned for ethnic minorities.

Limited knowledge tends to create homogenous groups where they don't exist and to skip over subtle but crucial distinctions, particularly between ethnic sub-groups (e.g., Samoans) and the larger groups of which they are a part (i.e., Asian Americans). Mexican Americans and Puerto Ricans may both be Spanish Speaking but between a Puerto Rican living in New York City and a Mexican American living in South Texas, vast differences in life style, culture and even language exist. The same kinds of distinctions have to be made among the different Asian American subgroups. Knowing someone is "Oriental" is as unsophisticated a basis for program planning as knowing someone is "European." We would not expect to teach a German Child in Russian, because German and Russian are both European languages, but some program planners and administrators seem to be ready

to assume that Chinese and Filipino needs are satisfied if there is a Japanese (Asian American) staff person in a social welfare agency. Similarly, the term "Indian" includes over two hundred different tribes, most with their own separate languages and cultures.

By being members of an ethnic minority group or subgroup, persons bring with them a particular world view, life style and orientation. They possess many strengths in their cultures that are superior to the dominant culture. But they are different and these differences must be taken into account in the designing and delivery of services to them. Navajos tend to live in small isolated family settlements, the Chinese tend to cluster. On a deeper level, the different groups have different orientations towards achievement, time, interpersonal relationships, respect for older persons, etc. . These cultural characteristics are not just ceremonial artifacts but pervasive and vital parts of their value system and way of life. It is these characteristics which define the substantial difference between just providing ethnic minorities with services for the "disadvantaged" and providing them with culturally sensitive services which reflected a respect for their culture and life styles. Ethnic minority individuals carry their frame of reference into a welfare office, a hospital or classroom. If, in the process of obtaining a service, they know they will confront embarrassment or conflict because of their cultural characteristics,

they may stay away or put off coming no matter how vital the service might be.

Illness is a particular problem. Being sent to a hospital too far away for family or friends to visit, unable to communicate with the doctors and nurses, served food that is antithetical to one's tastes, or religious beliefs, in a ward with White strangers from whom one has always withdrawn, is not the provision of medical care calculated to restore full health. The ethnic minority community groups interviewed by the Phase I consultants repeatedly raised these factors - inaccessibility and insensitivity of health services - and saw them as major obstacles to the delivery of adequate health services to their communities. The lower rate of usage and the higher rate of discharge due to death among minorities found in the Medicare Program indicate that the failure of most health facilities to view cultural factors as an integral part of a health delivery system has taken its toll on the ethnic minority population. On the other hand, the Maternal and Child Health Services project grant programs, many of which are oriented towards serving ethnic minority communities have proven to be successful in reducing the incidence of child death and serious illness in many of the areas in which they are located.

The Phase I study also indicated that the failure to take into consideration the different language and cultural characteristics of ethnic minorities can foreclose the possibility of education programs achieving their objectives in regard to ethnic minority individuals.

Non-English speaking students who are spoken to all day in a language they do not understand are likely to turn off to the educational process. Many ethnic minority groups have different learning orientations and different orientations towards "achievement" than White children do, so they may respond differently to the learning and rewards systems used in most schools. A variety of studies¹ have found a direct correlation between the failure of the educational system to respond to these differences and the low attainment and high drop-out rates cited for each of the ethnic minority groups in the "ethnic profile" section of this report. While bilingual/bicultural programs attempt to deal with cultural differences, the Phase I study found inadequate resources available for such programs. Title VII programs were serving only 1% of those needing such service, and school districts were not allocating other funds to support such programs. Perhaps a more dramatic implication of the connection between cultural insensitivity and school performance of ethnic minority students is found in a letter dated November 9, 1972, to Dr. Sidney P. Marland, Assistant Secretary of Education, DHEW, from the Chancellor of Higher Education of the State of New Jersey, citing a 100% drop-out rate of Puerto Rican high school students in Atlantic City and appealing for assistance in meeting "the desperate need for bilingual teacher and

¹ Reported by the Commission on Civil Rights in 1972. The Unfinished Education, 1971 and The Excluded Student, and Southwest Educational Development Laboratory 'Disadvantaged Mexican American Children and Early Educational Experience', 1968.

bilingual training resources." There is a critical shortage of teachers to conduct bilingual programs, but DHEW training programs are not producing enough new bilingual teachers to make a dent in the shortage. In such programs as Vocational Education, Bilingual Education, and EPDA curriculum developments, the Phase I study found a shortage of curricula especially designed for ethnic minority students. The need for allocating funds for bilingual/bicultural curricula, particularly for high school students and adults has gone unrecognized.

If DHEW is committed to serve and benefit ethnic minorities, the commitment entails providing culturally sensitive services where necessary, not because it is a nice thing to do, but because it is as essential a part of the service as is the doctor or teacher. Either one without the other means inadequate services for ethnic minorities and thus non-fulfillment of DHEW's mission.

The Phase I study indicated that a number of factors contributed to the failure of most programs to be responsive to the cultural characteristics of ethnic minorities. There are insufficient funds to meet the extra costs that are necessarily involved in adequately serving ethnic minorities.

Phase I revealed that DHEW Program staff often lacked a functional understanding of ethnic minorities and the requirements their cultural characteristics impose upon the provision of effective services to them.

The booklet "The Puerto Rican" in the National Rehabilitation Association's Ethnic Differences Series, is a model of the kind of material that can be prepared to

assist staff in obtaining a greater understanding of an ethnic minority group. Training materials such as these should be provided for other programs. Greater contact between planners and deliverers of service and the ethnic minority community will also increase understanding - in both directions. Perhaps even more important is the provision of bilingual staff, culturally attuned. Training and employing ethnic minorities, in providing services in the field as well as in planning, is the essential resource needed for providing culturally sensitive services.

However, a precondition to making services culturally sensitive is the actual existence of such services. A major finding throughout the Phase I study was that too often DHEW services never reached the ethnic minority disadvantaged community. The original appropriations have been inadequate to begin with, the allocation of sparse resources was inequitably assigned, and much that was assigned to the ethnic minorities was not designed to guarantee their full utilization of them. Therefore, a concern with culturally sensitive programs requires a concern for adequate resources, fair share allocation of those resources, strong guidelines, and a responsive accountability system to insure delivery of services, as well as a concern for the content of the services.

IV. C. Guidelines

Guidelines are the means by which DHEW converts Congressional intent into a workable plan of action. When guidelines are drafted, the interests of the ethnic minorities must be incorporated, if a program is to deliver services effectively to them. Guidelines must spell out the planning and allocation mechanism to be used at the Federal, state, and local levels in order to assure that each ethnic minority receives its fair share of the funds allocated, and to avoid diversion of these funds to other purposes.

Safeguards must be written into the delivery system to insure the ethnic minorities' particular cultural characteristics are considered, and the restraints they impose on the delivery of services taken into account in shaping the services so they will be culturally accessible to ethnic persons.

Head Start is an example of a program whose guidelines are culturally sensitive to the interests of ethnic minorities. It is also the program within DHEW that Phase I found best served ethnic minorities, quantitatively and qualitatively.

Effective guidelines may not be sufficient, in themselves, to insure that adequate service delivery is complied with; but they are a necessary requirement for an effective program. ESEA Title I guidelines offer an example of relatively good guidelines and with relatively poor local compliance. HEW has not enforced compliance during the

seven years of ESEA operation,

"Since the beginning of title I, the DHEW Audit Agency has reviewed the title I administration of most SEA's, but no efforts toward enforcements have been made. These audits are done in cooperation with the U.S. Office of Education, and often a State is not visited more than once every 3 years."¹

Nonetheless, with a new emphasis on compliance, for the first time in 1972,

"The U.S. Commissioner of Education has requested that \$24,491,184 be returned to the U.S. Treasury from the title I allocations of 31 States following discovery of audit exceptions by the DHEW Audit Agency. More money will be requested as the audits are completed State by State."²

Thus, the ESEA Title I guidelines enabled DHEW to prove a case of non-compliance in the utilization of funds at the local level. This served as the basis on which DHEW could demand reimbursement by the states for funds spent in violation of the guidelines at the local level.

Where the guidelines are not effectively drawn, such action to assure accountability is impossible. The Hill-Burton concept for the selection of priority service areas within a state failed to require that areas of greatest need, as stipulated by the Act, be selected for funding. By permitting funds to be allocated to top priority areas among the areas that applied for funds, the guidelines made it

¹NACEDC - Annual Report - 1972

²Ibid.

legally possible to divert funds from poverty areas to middle-class areas of lower priority. Loosely written guidelines make it difficult for program offices wishing to assure compliance with guidelines to undertake enforcement action against the states and other grantees. In other cases, poorly written guidelines do not spell out community participation in such a way as to assure effective participation of the community (e.g., Community Health Centers, Hill-Burton).

Well written guidelines, therefore, while not effective in themselves, at least establish standards by which a grantee can be held accountable. Poorly written guidelines contribute to ineffective service by foreclosing the opportunity for corrective action based on criteria established in the guidelines.

In a few of the programs studied (such as the Hill-Burton Act's provision for "reasonable volume of services") the Congressional intent to serve the disadvantaged in general (which includes ethnic minorities in particular) was lost because guidelines defining a "reasonable volume of service" were not issued for 25 years. But in most cases those guidelines analyzed in Phase I were issued and, on their face, appeared to be reasonably directed to program objectives, but frequently did not go far enough. Often the objective of serving the ethnic minorities was reflected in the guidelines, but often, even where a clear effort was made, there seemed to be an incomplete knowledge of characteristics of the ethnic minorities and

of the nature of their relationship with state or local agencies which administer the programs, thus resulting in weak guidelines from the perspective of protecting the interests of ethnic minority consumers.

The Hill-Burton program priority service areas guidelines did not provide for situations in which low income areas were unable to raise matching funds; the Supplementary Medicare Insurance (SMI) regulations did not take into account the fact that Indians will tend to use IHS even if health insurance is available to pay the costs of private health care; RSA guidelines gave counselors too much discretion in lieu of guidance in the disbursement of maintenance and transportation money; the Vocational Education guidelines' reliance upon public hearings as a means of involving the community in program planning effectively shut out ethnic minority participation.

The Phase I study repeatedly found that the issue on guidelines with regard to ethnic minorities was less a matter of will or intent - no one appeared to want to shortchange the ethnic minorities - but the absence of adequate mechanisms to assure that their interests are protected. To assure such an outcome, there is need for more input from the ethnic community and its organizations, but most particularly from ethnic minority staff employed in critical policy-making, program planning and related positions within the DHEW at the level of writing and reviewing guidelines. In addition, there apparently is a total absence of administrative mechanisms within

DHEW which would assure that ethnic individuals employed by DHEW routinely review guidelines and program plans to assure that the interests of ethnic minorities have been adequately considered. The role is a crucial one. The states and municipalities are already the primary deliverers of service and are likely to become the virtual exclusive deliverers of service at the local level under a revenue-sharing format. At that point Federal guidelines will become the only resource to assure that the special needs of the ethnic minorities are protected, and the only source of blueprints for mechanisms to assure that adequate and culturally sensitive services are available to the ethnic minorities. The development of model guidelines to guarantee fair share, culturally sensitive services to ethnic minorities in DHEW programs will be undertaken in Phase II.

IV. D. Accountability

Accountability is one of the basic management tools essential to any program system within HEW. The primary function of accountability systems is to insure that programs actually achieve the objectives set out for them in the legislation, regulations and guidelines. Functional accountability systems insure effective use of funds and resources and prevents their waste, misdirection or diversion from the purposes for which they allocated. In addition, sound accountability procedures must involve a continual flow of relevant program performance information to the program administrators so they can evaluate whether or not the guidelines are satisfactorily serving their intended purpose and/or being complied with at the service delivery level. In this manner sound accountability procedures provide a basis for redrafting guidelines where programs are found not to be performing as intended, or appropriate enforcement action where they are not being complied with.

An effective accountability system is particularly important to insure the delivery of culturally sensitive services to ethnic minorities. Until there are more ethnic minority staff at the policy-making level to participate in the program planning process, guidelines may skip over factors which are subtle, but crucial to the delivery of services to ethnic individuals. The guidelines may have to be redrafted as feedback based on analyses of program performance in the field which indicate their deficiencies.

Due to their small numbers, many of the ethnic minority groups do not have the political clout or advocates at the national, state or local level to compel enforcement of guidelines. Instead, they must rely on strong advocacy and enforcement.

The overall and consistent impression gained in Phase I is that DHEW program officers do not receive adequate information on the performance of programs as they relate to ethnic minorities; and where the information received has indicated that programs are not achieving their intended objective of serving ethnic minorities, program administrators have not responded aggressively by restructuring programs or taking forceful enforcement action to correct noncompliance. Frequently this is due to the lack of staff, data, ethnic resources (i.e., ethnic staff), and direction and support to perform these functions.

1. Reporting

The first requirement of an accountability system is feedback from the field in the form of data provided by the grantee administrators. The reporting should be accurate, designed to permit policy and program administrators to evaluate the program's performance, and to determine whether the program is reaching the population for whom it was intended and in a manner relevant to the objectives. An essential component of the reporting system should be data on the ethnic and racial characteristics of the beneficiary population. Data on the type and extent of service received by each beneficiary group should serve as the basic component of accountability.

A number of the programs studied during Phase I (i.e., Medicare, Vocational Education, Vocational Rehabilitation, Maternal and Child Health Services), do not require beneficiary data on ethnic minorities and often do not require sufficient information to evaluate a program's delivery in general. As a result, effective accountability for such programs and, particularly, how they impact ethnic minorities, is not possible.

State Plans are most deficient in this respect. The State Plan has frequently become merely a ritual, that once entered into, is renewed each year without changes, even though the funds available, service needs, the populations, etc., change - a minuet that is all form and no substance. State Plans tell DHEW little about the services offered to ethnic minorities. More often than not the ethnic minorities go unmentioned and unrecognized as a distinct consumer group with special needs.

Other reporting systems, such as the ones for Vocational Education do not provide sufficient information to determine whether in fact the 15% disadvantaged set-aside is being used to supplement other Vocational Education programs as required by the Act, or as a substitute for them, as specifically prohibited by the Guidelines. Reporting systems must be designed to give an

accurate picture of what the programs are doing individually and collectively in order to compare one program's performance with another. Ambivalent reporting systems permit grantees to hide the misuse or diversion of funds.

In other cases examined by GAO, grantee administration systems were so disorganized that they were incapable of submitting reports or submitted reports that were so confused they were¹ worthless. In some cases, grantees, just didn't² bother to submit the necessary reports at all.

The impression gained during Phase I study is that reporting is not taken seriously by the states and other grantees and many DHEW program officers are not clear about their role in requiring the states to comply with reporting guidelines.

2. Monitoring

Monitoring encompasses the analyses and interpretation of the reports that are submitted, as well as program evaluations and audits. During Phase I, various reports submitted by grantees were reviewed by the contractor. A number of the reports revealed gross non-compliance. Apparently, the reports rarely were read, interpreted, and most importantly, not acted upon (e.g., Vocational Rehabilitation).

¹ GAO report on Maternal and Child Health Services.

² Title I ESEA.

The same situation exists for audits and evaluations. Given the large amounts of money DHEW distributed, shockingly few audits are done. In a number of programs, states are required to audit local agencies, but this is also frequently not undertaken, or if done, violations of grant conditions are not acted upon.

There appears to be little confidence within DHEW staff (interviewed during Phase I) as to the validity or value of the evaluations carried out on consultant contracts or performed by DHEW staff.

An extremely informative study of evaluations in HSMHA was undertaken by Macro Systems, Inc.¹ In FY 71 alone, over \$32 million was expended by HSMHA and NIH to evaluate on-going programs. Macro Systems findings reveal:

1. There was lack of visibility associated with all studies.
2. The existence of the evaluations and implications of the evaluations are known to only a few staff.
3. There is little feedback and follow-up on the recommendations.
4. Their influence on administrative and policy decisions is limited.

During Phase I, difficulties were encountered in retrieving evaluations, but once located and read by

¹ The material on the Macro Systems study was taken from a precis of the study submitted by Macro Systems Inc. to DHEW.

UAI staff, many of those obtained were found to contain a great deal of information, particularly useful in assessing the problems of the delivery and quality of service available to ethnic minorities. However, some of the implications for ethnic minorities become lost because those reading the evaluations have not been sufficiently tuned in to the life situation and service needs of ethnic minority individuals. Since ethnic minorities are often not mentioned per se, staff do not see some of the evaluations' relevance to ethnic minority concerns and interests. However, if an evaluation discusses service to poverty groups in Texas, it is reasonable to assume that this information details services to Mexican Americans. Often even these basic implications are missed by insensitive or unknowing staff.

Evaluations should be analyzed and summarized, highlighting and isolating issues of concern to the ethnic minorities, in order to impact the operating agencies and their approach to and understanding of ethnic problems. At present, there is no administrative mechanism within DHEW prepared to perform this role nor does it appear that such a need has been fully recognized.

3. Enforcement

The information contained in DHEW audits, evaluations and reports does not seem to be adequately used by the agencies as a basis for action, either in influencing new policy-making or in compelling states and local agencies to comply with Federal guidelines.

This pattern was seen throughout the Phase I study: The Hill-Burton guidelines on designation of service areas, calling for boundaries which defined health care areas as opposed to county boundaries, were not followed. The intent of the highest priority service area guidelines, - to get health facilities into areas most in need - was never achieved. GAO found that Maternal and Child Health Services funds were diverted to general purposes, and that the Vocational Education 15% set-aside was often not being used for the disadvantaged. A PEBSI study found that a large percentage of Vocational Rehabilitation Service's clients did not meet financial eligibility requirements. Title I monies were diverted to supplant general school monies. Yet in none of these cases was the DHEW program administrator responsive. Guidelines were not rewritten nor was enforcement action taken, (except for Title I, which acted only after public outcries and strong outside pressure on OE). In all these cases, ethnic minorities were among the intended beneficiaries and often those most damaged

by the failure of DHEW to act. As a result, in many programs they have been denied services of any kind, let alone culturally relevant services.

In part, failure to act seems to be a function of staff shortages which deny staff the leisure to digest the audits and evaluations and integrate them into their action system. OE, across the board, is woefully understaffed to adequately administer a multi-billion dollar program. In BAVTE, only two individuals are assigned responsibility for monitoring performance of the 10 regional offices and 50 states.

The Phase I study also indicated that at least part of the reasons the guideline and accountability systems do not function at a maximum to insure delivery of services to ethnic minorities is that those responsible do not have the resources to perform adequately. They lack adequate data and other sources of input that allow them to become sensitive to ethnic minorities. They are unable then to develop an accurate profile of the characteristics of ethnic minorities as they differ from the general population and from each other in order to establish a realistic framework within which to plan and deliver services. As a result, decisions seem to be made on the basis of visceral reactions or on generalized and often naive perceptions about ethnic minorities.

Another apparent factor in DHEW's frequent failure to adequately enforce its own guidelines and thereby curtail the misuse of funds seems to be an attitude among DHEW staff that it is somehow inappropriate for the national office to enforce guidelines when the states are not in compliance.

Correspondingly, states typically do not exercise their obligation under many programs to monitor local grantees or to enforce compliance with program requirements. Past experience and the findings in Phase I support the hypothesis that unless the Federal government assumes responsibility for advocating and protecting the service needs of the ethnic minorities, their interests will go unprotected and more often than not, unrecognized.

Shortcomings in the guidelines, reporting monitoring and enforcement systems seem to be most acute in the formula grant programs, (Viz. Vocational Rehabilitation, Title I, Vocational Education, Maternal and Child Health). This is not to say that DHEW could not improve its handling of project grant programs. But Phase I found that although, comparatively, project grants are more effective in delivering services to ethnic minorities, the Federal trend is towards more formula grant programs, revenue sharing and decentralization to the regions, states, and local communities, making the practice within formula

grant programs of increasingly greater relevance. For some of the same reasons that they are the most likely victims of non-compliance and imprecise guidelines, ethnic minorities must rely almost solely on HEW's vigorous use of its enforcement powers to obtain compliance, and thus the services to which they are entitled. With the partial exception of Mexican Americans, the ethnic minorities are not in a position to protect their interests, most particularly vis-a-vis state, county and local government agencies - who are the administrators of the formula grant programs. These governmental entities have, for the most part in the past, been lax about meeting the needs of the ethnic minorities. Phase I has been replete with data and information, direct and indirect, in this regard.

Phase I found no evidence that DHEW formula grant administrators do not intend to be unresponsive to deficiencies in programs serving the ethnic minorities. Lack of information, oversight, insufficient sensitivity and lack of advocacy, however, can accomplish the same ends. The overall impression obtained in Phase I was not that program planners and administrators willfully disregarded the ethnic

minorities - it appeared that more than not, they were overlooked. Phase I led us to the conclusion that DHEW does have an "informal" policy of advocating program planning that is specifically responsive to the ethnic minorities (including the design of culturally responsive program services). However, the overwhelming impression is that for the most part this policy is informal and being such has never been fully communicated and/or interpreted to program offices, and, therefore, never effectively implemented.

IV. E. Community Participation

More than anyone else, the ethnic minority community knows what a culturally sensitive program should look like, and what barriers exist to the delivery of such services. The Phase I study indicated that communities have not been permitted to contribute significantly to the shaping of programs. However, most often it is not because the community does not know what it wants, but rather that it has not been given adequate tools with which to make its input. Also in a number of programs, community participation has been systematically frustrated.

In some of the programs studied in Phase I there are no regulations or guidelines requiring community participation. In a number of others, the provisions for community participation prescribed in the guidelines are inappropriate and therefore ineffective, particularly for ethnic minority communities. For example, various Vocational Education State Plans use public hearings as a means of obtaining community viewpoints. But the hearings are not held in places accessible to the ethnic community nor are vigorous and viable efforts made to inform them of the hearings. Public hearings have seldom been viewed by the disadvantaged community with anything other than distrust. The political and professional world take it as commonplace that what goes on in the public forum does not necessarily influence final decisions.

The ethnic community has also learned this lesson, though not necessarily how or why it operates that way or, more importantly, how to impact the level at which decisions are made. In other cases, DHEW agencies have redefined community participation requirements in a manner which vitiates consumer involvement. For example, Hill-Burton regulations require that 50% of program boards must be consumers of service. However, in 1968 new "clarifying" guidelines were issued suggesting that retired physicians and nurses would qualify as "consumer" board members. In many cases, community representation on city-wide or state-wide committees tends to blur the identity of a parent with his own school or health center. Small minority ethnic groups rarely achieve representation on such boards.

More explicit and realistic guidelines requiring community participation in program planning are essential to compensate for the tendency on the part of program administrators and professionals to think they alone know what is best for their clientele. However, even explicit and strongly worded guidelines, while necessary, may not be sufficient to insure meaningful community participation. A community cannot participate unless it has the resources that enable it to do so. On the most basic level it means having information concerning program implications and the ways various program decisions impact their lives. The Phase I study found that, generally, very inadequate mechanisms were utilized in communicating information to the community - particularly to ethnic minority communities where language and cultural differences were compounding factors.

For many programs with existing community advisory groups it is not surprising that they become little more than rubber stamps for administrative decisions. First, having had limited experience in such participation they are not familiar with the procedural aspects of exercising their rights and power. Similarly, they are not familiar with the programs' technical requirements, bureaucratic jargon, complex instrumentation for measuring output and, perhaps most importantly, do not see the relationship between many of these considerations and the concerns they have for themselves or for their children. Consequently, community groups usually find themselves in the position of having to respond to the agency administering the program, rather than being able to get the agency to respond to their needs and concerns. To the extent that technical assistance is available, it is usually provided by the administering agency and, in this context, is self-serving more often than not.

Thus, consumers may have problems with a program but may not be able to articulate it in programmatic terms. OEO and Model Cities have given citizen groups the funds to hire their own consultants, with some success. If this approach was adopted by DHEW, the Department might find that inarticulated feelings can often result in valuable contributions towards making the program more

culturally sensitive and thus, more effective. The overall findings of the PEBSI program tend to reinforce this view.

Furthermore, consumer participation for the disadvantaged can often be too expensive for the participant. Because the disadvantaged often hold more than one job, or the husband and wife both work (often on different shifts), or are single heads of households, they need to pay a babysitter to be able to attend meetings. Transportation also costs money. In the city it usually means public transportation. On the reservation a person may have to drive 100 miles to participate. In most programs, funds for consumer participation are allowable costs. Given the magnitude of the problem, DHEW should encourage more of its programs to provide such funds.

Finally, DHEW should put increased pressure on its grantees to develop more dynamic community involvement in programs serving the ethnic minorities. As with other aspects of this study, it may require some additional effort on the part of the programs. But, they will likely come to recognize that although they come from vastly different places and directions, more than not, consumers and program planners are committed to solving the basic problem - that of optimum responsive service delivery to the maximum number of people.

IV. F. Employment And Training

1. Employment At The Federal Level

DHEW has an obligation under Executive Orders and regulations established by the Civil Service Commission to avoid discrimination in hiring. But under its commitment to provide culturally relevant services to ethnic minorities, it has an affirmative responsibility to train and employ ethnic minorities for all programs, both project and formula grant, for which ethnic minorities are intended beneficiaries, and to require its grantees to do so similarly on a state and local level. There is no greater guarantee that ethnic minority considerations will be taken into account during program planning and monitoring than by having ethnic individuals in responsible staff positions. While Phase I revealed that the importance of this fact has been somewhat recognized for project grant programs, it needs to be emphasized for formula grant programs as well, where policy decisions and writing of guidelines seriously affect the distribution of program funds.

In Phase I a preliminary analysis was made of the relationship between the presence or absence of ethnic minority staff and ethnic minority funding in four programs, i.e., Student, Aid, Dropout Prevention, Family Planning, and RSA. A correlation was found between funding for ethnic minorities and the presence of minority individuals in policy-making positions. In the Family Planning program, for example, where there is a Spanish Speaking staff person at the policy level,

funding allocation by the program for Spanish Speaking is 2.4 times higher than the next highest funded programs for Spanish Speaking, and 8.3 times higher than the lowest.

The one exception is the Student Aid Program, where ethnic groups are apparently reasonably well-funded despite the lack of staff at the policy level. However, it is noted that student aid is influenced by efforts made at the local college and university level to involve a broader diversity of students.

Given the importance of ethnic staff at policy-making levels to assure that ethnic minorities receive their fair share of culturally sensitive services, DHEW's performance in employing ethnic personnel is dismally poor at all levels and shockingly so at policy-making levels, for both the national and regional offices. In view of the decentralization of decision-making from the national to regional level, ethnic minority input can be all but obliterated unless care is taken. If the staff cutbacks occur, special concern must be given to minority staff due to their shorter periods of tenure than other staff. At the regional level, employment statistics are particularly low for the different ethnic groups in the regions in which they have heavy concentrations of ethnic minority consumers. This bodes ill for the ethnic minorities, if planning responsibilities are decentralized as is planned.

The problem is apparent at all levels. The Office of the Secretary (OS) has only 4.4% of its

GS 13 and above positions filled by ethnic minorities. (See Chart A) Since the Office of the Secretary includes the Office of Special Concerns, the Office of Civil Rights, and the Office of Equal Opportunity (traditionally heavily represented with ethnic minority staff), this limited showing is of even greater concern. The Office of the Secretary serves as a model for other DHEW offices and its poor record is an overt expression of lack of commitment to ethnic minority representation.

A similar low pattern of employment of ethnic minorities was found in almost every agency at almost every level. The only exceptions are in programs specifically designated for one group and then only at the GS 1-7 level (e.g. Cuban Refugee Program or IHS.)

Chart A gives: 1) the percent of ethnic individuals in the general population of each region; and, 2) the percent of ethnic minority employees at different GS levels for each region, broken down for each ethnic group. In almost every instance the percent of ethnic minority employees at the policy-making level fails to equal the percent of that ethnic group in the general population. Since ethnic minorities make up a larger percentage of the DHEW client population because of the high percentage of ethnic minorities in the poverty population and the number of poverty-related programs administered by DHEW, a comparison between the employment figures and the percent of an ethnic group in the client population would show an even greater disparity.

Though not broken down by agency within each region here, a regional breakdown of ethnic minority employment by agency appears in a series of charts in the supporting data (Volume II). Some of the highlights of those charts are outlined below.

a. Spanish Speaking

In the Social Security Administration (SSA) only 0.5% of its employees at the GS-13 level and above in Headquarters are Spanish Speaking. There are none at that level in 6 out of the 10 regional offices, including Boston (I), New York (II), and Philadelphia (III), which serve almost all of the Puerto Ricans in the continental United States, with Region II being responsible for Puerto Rico itself.

When we exclude the Cubans in the Cuban Refugee Program in Region IV, SRS employs only 1.9% Spanish Speaking at any level nationally.

OE has no Spanish Speaking at any level in four of the regions (I, III, IV, VII) and only 2 Spanish Speaking employees (at the GS 1 - 7 level) in a fifth region (Region V). In Regions VI (Dallas) and IX (San Francisco) the percentage of Spanish Speaking employed in OE at Grade 13 and above is less than half the incidence of Spanish Speaking in the population of those regions. Only in Regions II (New York), VIII (Denver), and X (Seattle), does the percentage

of Spanish Speaking employed by OE at GS-13 and above equal or surpass their incidence in the regions' population.

HSMHA, Region IX, which covers California and Arizona, employs no Spanish Speaking in policy-making positions.

b. American Indians

HSMHA, which includes the Indian Health Services, employs 93.0% of all American Indians employed by DHEW.

90% of IHS employees are employed at the GS-1 - 7 level, although only 58.4% of all other employees of HSMHA are employed at the GS-1 - 7 level. The drop from GS 1 - 7 to GS 13 - 15 of the percentage of Indians employed by HSMHA is precipitous.

There are only 3 Indians employed at GS-13 or above in the Office of the Secretary, which includes the Office of American Indian Affairs. This seems to indicate that, except for OIA staff, Indians play a negligible role in national DHEW policy-making.

OE currently employs only one Indian at GS-13 or above in Headquarters. With the advent of the Bureau of Indian Education, more positions for Indians presumably will become available. Regions VI (Dallas) and IX (San Francisco) contain

about 50% of the total Indian population. There is not one Indian employed at GS-13 or above in OE in either region.

Nationally, SRS employs only 6 (0.3%) American Indians.

c. Asian Americans

In OE, there are no Asian Americans employed at any level in seven of the Regions and only 2 (at GS-1 - 7) in an eighth. In Region IX which contains 72% of all Asian Americans in the U.S., OE has no Asian Americans employed at GS-13 and above.

SSA employs no Asian Americans at GS 13 and above in eight of the ten regions. In Region IX where Asian Americans constitute 6% of the population, only 4.9% of the SSA employees GS-13 and above are Asian Americans.

SRS employs no Asian Americans at any level in seven of the Regions and none at GS 13 or above in Region IX.

It is unlikely that DHEW will be able to plan and implement culturally sensitive programs for ethnic minorities until it becomes culturally sensitive to its own staffing practices, particularly at the policy-making level.

2. State Employment

However inequitable and inadequate for purposes of culturally sensitive program planning

the ethnic minority employment picture is in DHEW, it is immeasurably worse in the state and local agencies which deliver much of the services. The statistics speak for themselves: from the state planning offices to the local welfare office and classroom they indicate an absence of ethnic minority staff in agencies delivering health, education, and welfare services. The Phase I study obtained a limited picture of the extent of the impact - Mexican Americans not getting welfare because there is no bilingual telephone operator; the elderly Asian American reluctant to go to a hospital because he knows he will be treated as inferior; the Indian child who gets turned off to education because he is spoken to only in a strange language he does not understand.

Data on ethnic employment at the state and local level is frequently spotty, which is part of the problem. All programs funded by the Federal government are required to keep racial data on their employees. But the requirement does not seem to be enforced. For example, almost 50% of the State Welfare Agencies did not report ethnic employment data. The states that do report employment data by ethnic group do not do so on the basis of

national standards or a standard data format. Some report on only one of the ethnic groups. Others lump different ethnic and racial groups together. In the absence of national standards for reporting ethnic employment data, it becomes almost impossible to compare or evaluate states' performance or apply the data that do exist in other useful ways.

Employment of ethnic minorities by states is a chronic problem. For example, only 2% of the state employees in New Mexico are Indian (Indians equal 7% of that state's population). In Arizona, which has a 6% Indian population, 1.6% of the state's employees are Indian.¹ The poor employment record is particularly damaging in the administrative offices of those programs that are directed at ethnic minority populations.

In Arizona there is not one Indian in the Title I ESEA Planning Office. In New York there is not one Spanish Speaking person in the Title I State Office. In Oklahoma,² the State Office is 100% White.

In the Vocational Education State Office, New York employs 0.3% Puerto Ricans, California employs only 4% Mexican Americans with only 1.3%

1 Navajo Times - Nov. 22, 1972 - Quote from John Buggs, Director of U.S. Civil Rights Commission.

2 Response to inquiries from State ESEA Title I Offices.

in any policy-making position. No data were available on employment of Asian Americans in the State Department of Vocational Education in California. Yet it is these same state and county offices which will be administering the revenue-sharing funds. Since the Federal presence in the the expenditure of revenue-sharing funds will likely be even less than it is for Title I and Vocational Rehabilitation, the absence of ethnic minority staff is even more critical a factor.

It is at the local delivery level that the negative effects resulting from underemployment¹ of ethnic minorities becomes most visible.

3. Local Agencies

Adair County in Oklahoma has a 40% Indian population but the county health department employs no Indians in key planning and administrative positions. The population of Caddo County, Oklahoma is 15% Indian and there are no Indians employed in the county health department. The death rate for "Negroes and Others" (in which Indians are categorized) in these two counties exceeds the national² rate by 20%.

In Tulsa, with the highest percentage of Indians in any urban center, Indians are represented in health department jobs, both

1 Response to inquiries made by UAI thru OCR of appropriate agencies.

2 Ibid.

at policy-making and lower levels, at approximately their population rate; Blacks are represented at almost two times their population rate. The county death rate for "Negroes and Others" is 13% below the national average.

The correlation found here is by no means simplistically explained and it needs to be followed up in Phase II. But the comparative figures do reinforce the picture seen throughout Phase I—that the ethnic minority staff in key positions are necessary for the delivery of effective service to ethnic minorities.

The same picture was presented by the Office for Civil Rights (OCR) in their compliance review of the Sonoma County Welfare Departments. It concluded that the county was not in compliance with Title VI of the Civil Rights Act. Its findings included the following:

Interviews with clients and caseworkers indicate that the absence of bilingual telephone operators has resulted in significantly greater burdens on Spanish Speaking potential clients as compared to other potential clients in terms of greater time delays, more required visits to the Department's office and, as a result, the additional burdens of child care, and transportation time and expense. Moreover, this breakdown of communication regarding general eligibility for benefits and enrollment procedures has led to a failure by Spanish-speaking clients to enroll for benefits to which they are entitled by law. Also case service workers who were not bilingual had to resort to using non-professional people as translators. These people frequently did not understand the eligibility requirements and therefore did not adequately explain them.

(While Spanish Speaking persons constituted 12% of the county's poverty population, they only constituted 5% of the welfare caseload.) There is ample reason to expect that the same situation exists for Asian Americans and American Indians elsewhere in the state.

4. Head Start

In general, Phase I found that the ethnic composition of the non-professional staff for Head Start reflects the ethnic composition of the children being served, as required in its guidelines. (These guidelines might be considered as a model for other programs operating throughout the Department with regard to bilingual/bicultural considerations.) The professional staff, however, does not reflect the same degree of ethnic representation. More non-professionals must be trained to move into professional positions.

5. Local Schools

Data on Selected School Districts obtained from OCR show clearly that in proportion to the number of ethnic minority children, there is a severe shortage of ethnic minority teachers; the result being that thousands of children with severe language and cultural barriers are receiving inferior education.

In 22 selected communities studied during Phase I, the proportion of Spanish Speaking teachers in grades K - 8 is less than one-tenth the number of Spanish Speaking students. For example, in Bronx County, 43% of the K - 8 students were Puerto Rican, while only 2.6% of the teachers were Spanish Speaking. In Los Angeles, 23.0% of the children were Mexican Americans, but only 2.1% of the teachers were.¹

The ratio for Indians is even worse. Nationally, there is one Indian teacher for every hundred Indian students.²

No definitive data was available on Asian American employment in local schools.

6. Training

In order to solve the problem of lack of trained ethnic minority personnel to fill policy-making and service positions, it is essential that a major commitment be made to train and certify more ethnic minority individuals to fill professional roles. Guideline directives in health, child development and education which are culturally responsive, (e.g., availability of a bilingual Vocational Education program) often

1 OCR/DHEW 1970 Directory of Public Elementary & Secondary Schools.

2 Indian Ethnic Consultant for Phase I Study.

cannot be fulfilled because of the lack of available qualified ethnic minority staff. This shortage is particularly severe among teachers, social workers, medical and health professionals, administrators, and child development professionals. As a result, ethnic minority consumers are not able to receive the benefits of Federally assisted programs free of cultural and language barriers.

There does not appear within DHEW, a strong policy commitment and, even less, follow through in training enough ethnic minority individuals to meet the obvious need, or of upgrading Mexican Americans, Puerto Ricans, American Indians, and Asian Americans so they may rise within the system to positions of greater responsibility. Many of the training programs do not keep data on funding or beneficiaries by ethnic composition, reflecting an insensitivity to the role of ethnicity in culturally sensitive programming or the magnitude of the need for ethnic personnel. But the major problem of training is not that ethnic minorities get short-changed in a number of the programs they have received substantial percentages of the training funds allotted. The problem is that the funding of training programs is

so minute that even a substantial percentage provides, in absolute terms, few newly trained ethnic minorities. At the present rate of funding, it is not likely that sufficient ethnic individuals will be trained just to keep up with the growth rate of the ethnic population. Virtually no dent is being made in the severe shortage of the trained ethnic minority service providers.

a. Education

The Education Professions Development Act (EPDA) has three programs designed to serve low-income persons. The Career Opportunity Program (COP) trains people from low-income communities to serve as educational auxiliaries. The Teacher Corps has developed programs to prepare teachers to work with bilingual children. The Basic Studies Programs includes a bilingual education program to train teachers for schools which use two languages for instruction. While no data was available on the Career Opportunity Program, ethnic minorities seemingly received about one-third of the funds under Teacher Corps and Basic Studies. But the total number of bilingual teachers trained in 1971 - 72 was only 70 for the nation.

There was no ethnic breakdown available on the TRIO program (Talent Search, Special Services for Disadvantaged Students, and Upward Bound).

b. Social And Rehabilitation Services (SRS)

Special funds were provided to state program offices of the Rehabilitation Services Administration (RSA) for in-service training of Vocational Rehabilitation staff. However, SRS does not require reporting by ethnic groups of persons receiving training; nor are the states required to report numbers of staff receiving agency training. It is thus impossible to determine the impact of such funds on ethnic minorities.

SRS committed 25% of all R & D training funds to a "Minorities Program." Although 25% seems to represent a generous allocation, all minorities represent 19.2%¹ of the total U.S. population. With the consistently low percentage of minority professional staff in welfare and social service agencies, an allocation of twice as much resources of all SRS training and demonstration (38%) of funds would be more in line with their needs. Because ethnic minorities, with one or two exceptions, have nothing comparable to Negro colleges, funding was given to universities that were near ethnic communities.

¹ The 19.2 figure is based on - Negro - 11.19%; Spanish Speaking - 4.6%; American Indians - 0.4%; Asian American (Japanese, Chinese, Filipino) 0.7%; "All Others" identified as Non-White - 0.4%, 1970 U.S. Census.

Such schools may or may not have a close association with the ethnic minority community. SRS might consider funding ethnic professional groups, or ethnic studies departments of universities to assure service to ethnic minorities. In addition, in neither of the two years the program operated was the program fully funded; reducing the opportunity to produce desperately¹ needed ethnic social service workers.

c. Health

The Bureau of Health Manpower Training has adequate resources and has funded a number of innovative programs. However, it does not have an effective system for informing those interested in its availability which seems to frustrate its use by ethnic minorities. The Office of Health Manpower Opportunity failed to fund any Asian American programs from its first set of grants.

The guidelines for Community Health Centers provide for training and career development for all health workers. Several of the Community Health Projects have been successful in providing considerable training of ethnic minorities for para-professional positions. At King City and Monterey County, California, more than 100 area residents have been trained in a variety of para-professional positions.

¹ Special Report prepared by the DHEW/OE Bureau of Higher Education

The Health Manpower Training Programs of IHS are too small, and IHS has not been able to evaluate adequately the program or their costs. In particular, more funds for training Indian professionals and an agency career development program to upgrade individuals currently in grades 8- 12 are sorely needed.

Special note is made of the status of the Indian Health Service with regard to employment, because it is subject to the provisions of the Indian Reorganization Act of 1934 and subsequent regulations and Executive Orders pertaining to Indian preference in employment. IHS Circular No. 71-1, establishing an Indian Health Service policy of granting Indians preference for employment and promotion within the Indian Health Service, represents a model minority employment policy even for those agencies not subject to the "preference provisions."

IHS's unique preference mandate could enable it to provide Indians access to jobs throughout DHEW. By instituting a vigorous career development program, it could act as a feeder to other agencies within DHEW, increasing Indian employment throughout the Department. Such a program could be coordinated through the Office of Indian Affairs, OSC.

IV. G. Data

Data is a useful, necessary tool for planning programs and monitoring their effectiveness. Because of these truisms, inadequacies in data systems make it difficult for anyone, no matter how well intentioned, to serve ethnic minorities effectively.

1. Census Data

Examination of the 1970 Census data that were available during Phase I¹ and comparing those to Beneficiary Data on specific DHEW programs when they were available, has produced evidence that ethnic minorities may have been undercounted in the Census. Numerous counties with high Mexican-American populations in the Southwest have been identified where the number of individuals enrolled in Medicare, according to SSA, is greater than the number of persons over 65 found by the Census. According to the Census, there are 35,000 Puerto Rican students K-8 in New York City, but the New York City public school system claims 50,000 Puerto Rican students enrolled in K-8. In Los Angeles, the Census reports 84,000 Mexican-American students in K-8, whereas the Los Angeles school system claims about 110,000. The Rand Institute of New York found that the Census undercounted the number of welfare cases in New York by 39 percent.

¹ Special Reports on Asian Americans and Indians were not available nor were the Detailed Characteristics for U.S. or the States Series available.. All will be available during Phase I

Census data are extremely important because formula grants utilize Census data in one form or another as the basis for allocating Federal monies. When a program's allocation formula gives added weight to the size of the poverty population in a given area, an undercount of ethnic minorities can substantially decrease the size of the area's allocation. When ethnic groups evade the Census, i.e., Chinese living in quarters not considered acceptable, or Mexican Americans concerned about the legality of their alien status, the problem of a correct count is exacerbated.

With the new emphasis on revenue-sharing which uses Census data as the basis for allocation, (usurping project grants which are awarded on the basis of need), the problem assumes additional importance.

Census data is also essential for accurate planning. The ability of an ethnic minority group to make a case for a particular service depends largely on data on levels of poverty, school retention rates, females in the labor force with children under 6, etc. Such substantiating data relies heavily on Census data. Since an undercount usually misses the poorest, least visible of a group, it tends to hinder that

group from substantiating the problems it is certain exists in its community.

Further study is essential in determining the source of Census data errors and to document the information for use by DHEW in program planning. Such research is vital in assuring accuracy of formulae that are utilized in determining allocation of DHEW funds.

2. DHEW Data

The Codes identifying each program differ throughout the Department, and it is therefore extremely difficult to assure that program data are comparable. Since the code name (or number) is an arbitrary number fed into the computer to identify programs or subsections of programs, or the Bureaus that administer programs, in order to align information coming from one computer with information coming from another, it would be rational to utilize the same code number throughout the Department to refer to the same program. Thus, the employees in a Bureau, the funds expended by the Bureau, the beneficiaries receiving service from the funds expended by the Bureau, should all have the same code number so that anyone receiving a printout from the Office of the Secretary, the Office of Education, the Equal Employment Opportunities Office, etc., could immediately align a program with its staff and its

beneficiaries, without having to utilize different descriptions and attempt to equate them to the different code number on each computer.

Evidence that data submitted is inaccurate, poorly compiled, etc., comes from program after program. This is particularly true of data accumulated under the formula grants, but is also a problem for the project grants. GAO reported on Children and Youth Projects:

1. The fact that the data submitted by many projects was untimely, incomplete, and inconsistent.
2. The fact that some projects did not report at all, even though reporting was mandatory.

The use of data as a source for management information and management decision-making should be stressed. The capacity to accumulate data as per program requirements as a condition for obtaining Federal funds should be established and enforced. Congress makes yearly allocation decisions on the basis of such information.

3. Ethnic Data

Most programs in DHEW do not collect data by ethnic minority beneficiaries. Instead, ethnic minorities are subsumed in various general categories: "Negro and Other," "Other," "Oriental," etc. In addition, the present system is inconsistent.

Since such data are essential to determine who is receiving what services under what circumstances, the number of categories which provide no usable information seems excessively high. 18% to 35% of the funding for the three fiscal years 1971-1973 was listed under categories such as "Other Minorities," "Mixed Minorities," "All Others," "Unallocable," etc. A long list of ambiguous definitions is provided by the data management system to define these terms. The number and complexity of the definitions, their tendency to overlap and the infrequency with which some categories are used seriously adds to the difficulty of determining to whom and in what amounts DHEW funds were granted. At present, more than 50% of the funds expended by the Office of Education cannot be identified ethnically. It is almost certain that funds loosely allocated to mixed minorities, or "unallocable," are not taking into consideration the cultural requirements of the individuals for whom the programs were designed. A major effort should be made to eliminate as many of the obscuring categories as possible.

Since ethnic minorities are lost in the data categories, it is not surprising that programmers frequently fail to focus on them in the planning and delivery of services. In addition, without

clear data on where they are, what their needs are and how their individual needs are different, it is virtually impossible to plan and provide culturally sensitive services to the different ethnic minority sub-groups. At best they are treated as a homogeneous mass; at worst they are forgotten altogether. It is imperative, in order to protect the interests of the ethnic minorities, that data on Spanish Speaking, Asian Americans and American Indians be categorized separately rather than subsumed under general categories. Where appropriate, data should be collected by subgroup. If the masses of data presently available for Blacks throughout the agency can be accumulated, then it is only reasonable to assume that it is possible to accumulate similar data on Spanish Speaking, Asian Americans and American Indians. It is critical not only for statistical usefulness of the data, but because it contributes to the consciousness of their existence among program planners and administrators, and indicates that they are considered as populations of consequence.

Data on allocation of Office of Education program funds, by program, was received from both the Office of Education Program and Financial Planning and the DHEW Data Management Center, Division of Data Processing. The data in the two reports were not the same, but several categories

had major differences in numbers of individuals served by ethnic groups and amounts of funding to them.

In addition, data from the Bureau of Elementary and Secondary Education were not in accord with data from the ESEA Title VII office; and, both were not in accord with computerized data provided by the DHEW Data Management Center. Thus, there was evidence of serious data discrepancies on the same programs in "official" data emanating from Bureaus, Offices and the Department. Such differences present a difficult problem when a variety of people in different sections of DHEW are trying to plan for a given program.

There is a great deal of confusion within and without government about terminology for Spanish Speaking persons - Spanish origin; Spanish surnamed; Spanish speaking; etc. The use of different terminology makes it difficult to know when one is working with the same population. It is never quite clear if the terms all define the same population. For example, "Spanish surnamed" includes all persons with Spanish surnames (including Filipinos, for instance), whether or not they speak Spanish; while "Spanish speaking" ignores all Spanish surnamed who do not speak Spanish. An effort should be made to clarify the terms and end the confusion.

Data on ethnic minorities would be most useful if they were maintained both for funds expended and beneficiaries served. Without both beneficiary and cost data, it is difficult to measure the impact of many programs on ethnic minorities. Eventually beneficiary data could be further defined by identifying applicants vs. those served and delineating types of service by ethnic group. With computer storage, such information is easily codified, summarized and retrieved. In the meantime, there is no way to determine, for example, whether the extra cost necessary for operating a bilingual program, or developing culturally sound curricula, or providing bilingual staff in service agencies, has cut down on the number served unless we can compare beneficiaries with costs, and not be required to rely merely on costs and make assumptions in the absence of information. Ethnic breakdown of both funds expended and beneficiaries served is necessary to assure that allocation formulas are being adhered to.

IV. H. Allocation

Most of the various programs within DHEW try to allocate their services among the various poverty populations in the country so that each group will benefit equitably from the program. The decision as to what percent of a program's benefits will go to a particular group is made by deciding how much money will be allocated to serve that particular group. For project grant programs, allocation decisions are made within the planning office responsible for administering the program. For formula grant programs, the decision is made by the state or local grantee on the basis of the formula established by Congress in the law, as interpreted by DHEW regulations and guidelines. Either way, an effort is made to distribute the funds equitably allegedly based on the need for the services. However, the present allocation formulas used by DHEW office, on the one hand, usually do not allocate a fair share of funds to serve ethnic minorities based on their need for the services and, on the other hand, tend to discriminate against ethnic minorities because of their ethnic characteristics.

One formula commonly used is "incidence in the general population." If Spanish Speaking constitute 4.6% of the general population, it is reasoned that they need 4.6% of the services. 4.6% of the funds are allocated to serve them and the program is considered successful if 4.6% of those served are Spanish Speaking. However, most programs within DHEW are designed to serve persons in poverty and incidence

in the general population is not an accurate indicator of a group's need for a particular service. Ethnic minorities have a substantially greater incidence in the poverty population and therefore have a greater need than is reflected by their incidence in the general population.

Other programs use an "incidence in the poverty population" formula. While an improvement on "incidence in the general population," it still denies ethnic minorities a fair share of services. The implicit assumption of the "incidence in the poverty population" formula is that all poverty populations are homogenous and that a particular population's incidence in the poverty population is the accurate indicator of that population's need for a particular service. It assumes that if Spanish Speaking constitute 8% of the poverty population, they need 8% of the education services, 8% of the services for the aged, etc. But data gathered during Phase I indicate that incidence in the poverty population is not a consistent indicator of a group's need for a particular service since the population "at risk" and the need for service varies from program to program for each ethnic group and subgroup. For example, while Whites comprise 60% of the poverty population, a very large portion of poor Whites are 65 and over, or single unrelated adults. Therefore, Whites may need a greater proportion of funds for the aged, but not 60% of the Head Start or education funds. On the other hand, ethnic minorities tend to have large families and thus have a greater need for education and early childhood health services than would be indicated by their incidence in the total poverty

population. For example, in Bronx County, 21.5% of the total poverty population is Puerto Rican, but 50.7% of the 3 - 4 year olds in the poverty population are Puerto Rican. Whites on the other hand, constitute 59.9% of the total poverty population but only 17% of the 3 - 4 year olds in the poverty population. This same pattern for 3 - 4 year olds is repeated around the country for all of the ethnic minority groups, each reflecting its own unique characteristics which often differ from one ethnic group to another.

Thus, under the "incidence in the poverty population" formula, funds for Head Start services in the Bronx would not have gone to those who needed them in proportion to their need. To prevent misallocation of resources, the formula process needs to be carried one step further and measure the incidence of need for a specific service by each of the groups constituting the poverty population, i.e., of 3 - 4 year old Puerto Ricans in the poverty population. Similarly for the 15% set aside for the disadvantaged under the Vocational Education program, the formula (except for the work study and community college components) should be based on the incidence of non-college bound 15 - 24 year old Puerto Ricans having language or other learning difficulties. The more sophisticated formula permits a program to more accurately direct its funds to those most in need of its services. For determination of the "at risk" population for each ethnic minority group for such programs as infant and child health programs, and most education programs, it means

a fairer share of funds to ethnic minorities and a higher probability that programs will impact intended target populations.

However, given that DHEW's intent is not just to allocate funds for services but to benefit people, to bring its beneficiaries from one point to another (to better health, greater achievement in school, etc.), even the more sophisticated allocation formula proposed above does not provide ethnic minorities with a fair share of funds for services. The above formula would serve the different groups equally well only if the cost for service was the same for different groups. Almost all services to an ethnic minority will cost more than to a Black or White group because of such additional costs as the cost of a bilingual telephone operator, who is necessary to enable an ethnic minority to take the first step towards obtaining medical assistance.

Providing the ethnic minority with services equivalent to those received by the rest of the population usually means developing bilingual materials, perhaps, as for Indian tribes, from scratch; hiring interpreters or training ethnic minorities for professional positions; more extensive outreach and transportation services, etc.

A consistent finding of Phase I is that for almost all programs, it simply costs more to provide an equivalent level of services to ethnic minorities. Allocation of funds on the basis of incidence in a population, even for the

specific population "at risk", does not take the additional cost factors into account. If it costs \$10 to provide an adequate level of service to a White beneficiary but \$20 to provide an equivalent level of service to an ethnic minority consumer (assuring equal incidence in the population) then allocating \$100 to each group does not provide for equitable allocation. The \$100 either serves only 5 ethnics as compared to 10 Whites, or provides a service that is not biculturally appropriate and thus less effective, to 10 ethnics. Either way, it penalizes ethnic minority consumers solely because of their ethnic characteristics. A policy commitment to equitably serve ethnic minorities, almost by definition means a commitment to spend more money per beneficiary.

With the imminent conversion of most project grant programs to a revenue-sharing structure and decentralization of decision-making to the regional offices under FAR, it becomes critical to the interests of the ethnic minorities that guidelines be written into such programs which compel states and local communities to adopt allocation formulas that will take into account the composition of the needs characteristic of particular populations of ethnic minorities and the fact that effective services for ethnic minorities cost more than equivalent services for other groups in the population. The alternative is an ever-widening gap between ethnic minorities and the rest of the population in levels of health, education, and welfare.

V. OBSERVATIONS AND IMPLICATIONS

A. Introduction

Phase I was a four month survey of the extent of delivery of culturally relevant services to Spanish Speaking, Asian Americans and American Indians. Its primary objective was to identify the major problems that inhibit the delivery of such services. The Observations and Implications Section is an index of some of the major issues, problem areas, and needs identified by the Study, and discussed in the report. It is not intended as a capsule summary of the Report since most of issues identified are too complex to be accurately summarized in two or three sentences. The implications and observations do provide a ready index of the different issues raised, permitting the reader to refer back to that section of the report in which the issue is developed. To facilitate this, the relevant section of the report from which the implication is drawn is provided after each paragraph. An asterisk(*) follows those issues which will be followed up on in Phase II. But all the issues raised are crucial to the delivery of services to ethnic minorities and must eventually be dealt with if the quality and quantity of those services are to improve.

During the period of time this report was written, radical changes have occurred - impoundments of funds scheduled for FY 73, budget cuts proposed for FY 74, projected staff reductions, decentralization of decision-making authority to the Regional Offices, proposed revenue sharing and further decentralization. Because most of these changes accelerated after the data for the report was compiled, but before the final

Phase I Report was written, it has been necessary to by-pass many of the implications of many of the changes that have occurred since October 1, 1972. The implications of the changes as they affect the ethnic minorities will be considered as part of the Decentralization Study that will be undertaken as part of Phase II. One point must be emphasized however - the changes have increased dramatically the already crucial need for HEW to assume ethnic minority advocacy to the state and local level.

It is evident that all the ethnic minorities have serious problems in areas that HEW is mandated to serve. Although needs differ in degree and emphasis from subgroup to subgroup, all groups need substantially more DHEW-funded services than they are now receiving, and it can be projected that the funding cuts are likely to provide less monies to meet their crucial needs.

There is a need for more data on all of the groups in order to present a functional portrait of the problems facing the ethnic minorities. This need is particularly essential for the Asian Americans. During Phase II, such further data as will become available will be analyzed.

Nowhere in Phase I, (except in the Ethnic Offices themselves), either in written reports or evaluations received from DHEW, or from interviews with DHEW personnel, did the researchers find a clear commitment to the right of cultural survival of the ethnic minorities, as such. We did find a

general, albeit usually vague, commitment to "serve" the needs of the ethnic minorities. Usually this commitment was more a commitment to the "disadvantaged" rather than to the ethnic minorities except as a member of that group. For the most part, there was not a distinct recognition of the special problems which face the ethnic minorities in attempting to utilize DHEW services. Too often, HEW programs and administrative personnel viewed the legitimate service needs of ethnic minorities as "cultural barriers to service." This concept converts the ethnicity of their life styles into a "problem" and places the onus for culturally-related problems on the ethnic minorities themselves, not on the limitations of the service delivery systems and program planning processes.

By being members of an ethnic minority group or subgroup, persons bring with them a particular world view, life style and orientation. They possess many strengths in their cultures that are superior to the dominant culture. But they are different and these differences must be taken into account when designing and delivering services to them.

If DHEW is committed to serve and benefit ethnic minorities, the commitment entails providing culturally sensitive services where necessary, not because it is a nice thing to do, but because it is as essential a part of the service as is the doctor or teacher. Either one without the other means inadequate services for ethnic minorities and thus non-fulfillment of DHEW's mission.

The Phase I study found that a basic resource needed by program planners and administrators to enable them to

improve the delivery of culturally sensitive services to ethnic minorities is a deeper understanding of who ethnic minority individuals are and the implications of their cultural orientation and life style for the planning and delivery of services. As it has been necessary to learn the characteristics of poverty and the restraints they impose on an effective delivery system, a similar lesson has to be learned for ethnic minorities.

However, a precondition to making services culturally sensitive is the actual existence of such services. A major finding throughout the Phase I study was that too often DHEW services never reached the ethnic minority disadvantaged community. The original appropriations have been inadequate to begin with, the allocation of sparse resources was inequitably assigned, and much that was assigned to the ethnic minorities was not designed to guarantee their full utilization of them. Among other factors, they are simply too small in numbers, have too few professionals on DHEW staff, and lack sufficient political "clout" to assert their rights and interests vis-a-vis other beneficiary groups.

Therefore, a concern with culturally sensitive programs requires a concern for adequate resources, fair share allocation of those resources, strong guidelines, and a responsive accountability system to insure delivery of services, as well as a concern for the content of the services.

A number of specific findings were made in Phase I. The salient implications resulting from the study are presented below:

B. Guidelines

1. Guidelines in most programs have failed to provide a foundation for the delivery of culturally sensitive services to ethnic minorities. The guidelines have not provided for the kinds of delivery systems which will insure that service resources intended for ethnic minorities reach them and are not diverted to other purposes. Also, in the majority of cases, the guidelines have not required the deliverers of services to consider the particular characteristics of ethnic minorities. Yet with the imminent conversion of most of the project grant programs to a revenue-sharing structure and the decentralization of decision-making to the regional offices, the need for DHEW guidelines that are sensitive to ethnic concerns becomes more critical. (IV C)*

2. HEW's failure to draft guidelines that are responsive to ethnic minority considerations seemed to be the result of inadequate administrative policies and mechanisms to assure that their interests are protected. These included inadequate input

from the ethnic community, and a dearth of ethnic minority staff employed in critical policy-making, program planning and related positions within DHEW. Also there is no administrative mechanism within HEW which would assure that such ethnic individuals employed by DHEW routinely review guidelines and program plans to make certain that the interests of ethnic minorities are being adequately considered. (IV C)

C. Accountability

1. An effective accountability system is particularly important to insure the delivery of culturally sensitive services to ethnic minorities because: a) Initial guidelines may tend to skip over factors which may be subtle, but are, nonetheless, potentially fatal to the effective delivery of culturally sensitive services to ethnic individuals. These problems need to be picked up and corrected through a sensitive reporting and evaluation system and a responsive mechanism for redrafting guidelines; and b) Since ethnic minorities have little political influence, only a strong enforcement effort by DHEW can insure that guidelines will not be flouted or resources diverted from the provision of services to ethnic minorities. (IV D)

2. The overall and consistent impression gained in Phase I is that DHEW program officers do not receive adequate information on the performance of programs as they relate to ethnic minorities.

Where the information received has indicated that programs are not achieving their intended objective of serving ethnic minorities, program administrators have not responded aggressively by restructuring guidelines or taking forceful enforcement action to correct noncompliance. (IV D)

3. Reporting is not taken seriously by the states and other HEW grantees and many DHEW program officers are not clear about their role in requiring the states to comply with reporting guidelines. As a result, reports are often not submitted at all. A number of those reports that were submitted by grantees in various programs revealed gross non-compliance. Apparently, many of these reports were not read or interpreted and, if read, were not acted upon. (IV D. 1.)

4. The State Plan is an inadequate tool for assuring that the legislative concern for the specific needs of ethnic minorities is translated into effective action. State Plans rarely influence program operations and are more a rote response to a bureaucratic requirement than a valid and effective planning tool. The plans are near worthless in terms of discovering what the state agencies intend to do and, in particular, what service they intend to offer ethnic minorities. (IV D.1.)

5. Frequently, the implications for ethnic minorities in program evaluations tend to be missed by staff. Evaluations should be analyzed and summarized; highlighting and isolating issues of concern to the ethnic minorities. At present, there is no administrative mechanism within DHEW prepared to perform this role nor does it appear that such a need has been fully recognized. (IV D. 2)*

6. The information contained in DHEW audits, evaluations and reports does not seem to be adequately used by the agencies as a basis for action, either in influencing new policy-making or in compelling states and local agencies to comply with Federal guidelines. (IV D. 3)

7. Factors in HEW's frequent failure to adequately enforce its own guidelines and thereby curtail the misuse of funds include:

- a. Staff shortages which deny staff the leisure to digest the audits and evaluations and integrate them into their action system. OE, across the board, is woefully understaffed to administer adequately a multi-billion dollar program.

- b. Inadequate data to allow staff to develop an accurate profile of the characteristics of ethnic minorities as they differ from the general population and from each other, in order to establish an adequate framework within which to plan and deliver services.*
- c. An attitude among DHEW staff that it is somehow inappropriate for the national office to enforce guidelines when the states are not in compliance. (IV D. 3)

D. Community Participation

- 1. While the ethnic minority community knows what a culturally sensitive program should look like and what barriers exist to the delivery of such services, the Phase I study indicated that community groups have not been permitted to contribute significantly to the shaping of HEW-funded programs. More explicit and realistic guidelines requiring community participation in program planning are essential to compensate for the tendency on the part of program administrators and professionals to think they alone know what is best for their clientele. Also, better mechanisms and additional resources must be provided to communities to enable them to participate in a meaningful way. (IV E)

2. Evidence that data submitted by DHEW-funded agencies is inaccurate, poorly compiled, and misleading comes from program after program. This is particularly true of data accumulated under the formula grants, but is also a problem for the project grants. The accumulation of accurate data should be made a condition for obtaining Federal funds; once established the rule should be enforced.
(IV G. 2)

3. Examination of the 1970 Census data available during Phase I and a comparison with Beneficiary data on specific DHEW programs when available, produced evidence that ethnic minorities may have been undercounted in the 1970 Census. Accurate data is essential to the service interests of the ethnic minorities since Congress, HEW, and states make yearly allocation decisions on the basis of such data. With the new emphasis on revenue-sharing which uses Census data as the basis for allocation, (replacing project grants which are awarded on the basis of specific need), the problem assumes additional importance. (IV G. 1)*

4. Many HEW programs do not accumulate beneficiary data for ethnic minority subgroups. Ethnic minorities are subsumed in various general categories: "Negro and Other", "Other"). Without clear data on where they are, what their needs are, and how their needs differ, it is virtually impossible to plan and provide culturally sensitive services to different ethnic minority subgroups. The result is that they are usually treated as a homogeneous mass, or are forgotten altogether. (IV G. 3) *

5. There is a great deal of confusion within and without government regarding terminology used to identify Spanish Speaking persons: Spanish origin; Spanish surnames; Spanish speaking; etc.. The use of different terminology makes it difficult to know when one is working with the same population. An effort should be made by HEW to clarify and standardized the terms and end the confusion. (IV G. 3)

E. Allocation

1. Ethnic minorities have a substantially greater incidence in the poverty population at large, and an even higher incidence in the poverty population needing child, youth, maternal health and education services than is reflected by their incidence in the general poverty population. Fair share allocation must take into consideration the poverty, the age, and the need for services, as well as the distribution of population. (IV H) *

2. Phase I found repeated evidence that cultural programming, by definition, costs more money and relatedly found little evidence of a real understanding of that fact and/or its implications within the various program offices. Utilization of bilingual staff and, where necessary the training of that staff, the development of curricula, the decentralization of service, etc., are all added essential costs for a program if it is to be culturally responsive. (IV H)

F. Employment and Training

1. Within DHEW, ethnic minority staff at policy-making levels is the best guarantee that ethnic considerations will be taken into account in the planning and monitoring process. Phase I found correlation between the existence of ethnic minority staff in a program and high program funding for ethnic minorities. (IV F)

2. HEW's performance in employing ethnic minorities is dismally poor at all levels and shockingly so, at policy-making levels. In the DHEW national office and for every region, with few exceptions, the percent of ethnic minority employees at the policy-making level fails to equal the percent of that ethnic group in the DHEW client population or even the general population. At the regional level, employment statistics are particularly low

for the different ethnic groups in the regions in which they have heavy concentrations of ethnic minority consumers. This bodes ill for the ethnic minorities as the Regions assume the planning responsibilities. (IV F.1)*

3. Indian Health Service's mandate to give preference to Indians in hiring and promotions could enable it to provide Indians with access to jobs throughout HEW. By instituting a vigorous career development program, IHS could act as a feeder to other agencies within HEW, increasing Indian employment throughout the Department.*

4. From the state planning offices to local welfare offices and classrooms, statistics gathered during Phase I indicate an absence of ethnic minority staff in the state and local agencies delivering health, education, and welfare services. Since the Federal presence in the expenditure of revenue-sharing funds most likely will be even less in the future than it is now, the absence of ethnic minority staff at the state and local levels becomes an even more critical a factor. (IV F 2,5)*

5. While the need for ethnic staff seems to be recognized to some degree within DHEW, the state and the local level, the link is rarely made to the absence of training to develop the staff and to the responsibility of HEW to assure that such training is made available. As a result, within HEW, there does not seem to be a strong policy commitment to train and/or upgrade ethnic minorities to meet the recognized need. (IV F.6)*

G. Hill-Burton Program

1. The Hill-Burton program, designed to benefit particularly those persons unable to pay for health services has, in practice, largely been a subsidized hospital program for the middle-class in which the rights of the poor and the ethnic minorities to service have not been protected. (III B.)

2. Hill-Burton service areas were to be drawn to designate a cohesive and functional community for health facilities purposes. These criteria were rarely followed in establishing service areas. This specifically hurts the ethnic minorities by eliminating convenient access to facilities which are responsive to the life situations of local consumers called for in the guidelines for establishing service areas. (III B. 1.)*

3. Contrary to the legislative intent, high priority service areas are not the ones which ultimately received Hill-Burton funds. Poverty communities with high concentrations of ethnic minorities, while high priority, lack the matching funds or the ability to raise them, do not apply, and as a result completely drop out of the states' system of establishing Hill-Burton priorities. The guidelines should mandate that the priorities be based on community need rather than on those areas which can raise matching funds. Such action would enable states to focus their funds on the high priority areas with the greatest need. (III B.2)

4. The 1970 Amendments to Hill-Burton permit the states to fund up to 90% of the total costs of health facilities to poverty areas instead of the 2/3 - 1/3 formula. Almost all states have decided to spread their Hill-Burton funds to as many projects as possible and have decided not to permit a local community to obtain 90% of federal share. The result of this policy on the part of the states has been that little or no increased Federal assistance under the Hill-Burton program to poverty areas occurred. (III B.3.)

5. Hill-Burton health facilities were not required to provide services to the poor because implementation guidelines spelling out what constitutes "reasonable volume of service" to poverty groups in hospitals and other health facilities receiving Hill-Burton funds were not promulgated until April, 1972, twenty-four years after such a requirement in the legislation was enacted. With the seeming cessation of Hill-Burton construction, DHEW's vigorous enforcement of the "reasonable volume of services" regulation becomes the only way left for the poor - the primary intended beneficiaries of the Act - to gain improved health services from the massive expenditures made under Hill-Burton. (III B.21)*

6. Ethnic communities perceive serious problems of discrimination against them by medical facilities both in the delivery of services and in employment practices. The

absence of monitoring of compliance with Title VI of the Civil Rights Act for Hill-Burton funded facilities encourages this problem. A first step in providing culturally sensitive health services is to guard against or eliminate overt and illegal discrimination in services and employment of ethnic minorities where it exists in Hill-Burton funded facilities (III B. 5.)

H. Medicare

1. Medicare does not maintain data by ethnic breakdown. Knowing the rates of Medicare usage by ethnic minorities would enable DHEW to draw a fairly accurate picture of how much medical care elderly ethnic minorities are actually receiving. This kind of information is necessary for HEW to design a total strategy for raising the low life expectancy of ethnic minorities. (IIIC.)

2. The poor and "Negros and Others" have much lower enrollment rates for Supplementary Medical Insurance (SMI) than does the population as a whole. There are indications that enrollment of ethnic minorities is as low or lower than the percent of Blacks. Social Security Administration's new automatic SMI enrollment policy for all Social Security beneficiaries will insure that a greater number of minority elderly will be covered by SMI, but it still leaves the unresolved problem of the high percentage of ethnic minority elderly not covered by Social Security (e.g. 52% of the Spanish elderly poor.) (III C. 2.)

3. Inaccessible health facilities and insensitive treatment of ethnic minority individuals has seemingly inhibited the ethnic minority elderly from using Medicare (Hospital Insurance and SMI). They use it less frequently than do Whites, and when they do use it, they tend to stay in hospitals for longer periods and experience higher rates of "patient discharges due to death." (III C. 1)

4. The problems of insensitive and discriminatory health services can be dealt with. The Office of Civil Rights, HEW, could do much to promote culturally sensitive behavior on the part of health facilities receiving Medicare funds. The alternative appears to be the continued less frequent use of Medicare by the elderly in need of service and the continued lower life expectancy for ethnic minorities. Given SMI's new automatic enrollment policy, unless the problems of insensitive health care services are dealt with, more ethnic minority elderly will be signed up and paying premiums for SMI, but they will continue to use the benefits at a lower rate. The end result of the new policy will be to do little more than take money from the checks of many minority individuals, while subsidizing medical insurance for "Whites". (III C.2)

I. Maternal And Child Health Services

1. States rarely followed the Federal guidelines for reporting Maternal and Child Health Services (MCHS) formula grant expenditures and, by failing to do so, avoided providing MCHS with any usable information on expenditures or performance. Behind this inadequate reporting by the states, there is evidence of

intentional diversion of MCHS funds to purposes not provided for in the legislation or the regulations. (III D.)

J. Community Health Centers

1. Initial results indicate that Community Health Centers are succeeding in providing meaningful health care to poverty communities including some ethnic minorities. With the high incidence of disease among ethnic minorities, there is a need to continue and expand these programs. (III E.)

2. The expenditure of \$92 million on Maternal and Child Health Centers (project grants) has materially reduced maternal and infant death rates, the incidence of disease among children, and per patient cost of service in poverty areas. However, the prospect is that the Maternal and Child Health project grants are likely to lose their authorization at the end of FY 1973. Most states in which MCHS Centers exist will not have the funds available to continue operating. The loss to ethnic minorities will be considerable. (III E.)

K. Bilingual Education

1. Title VII, ESA (Bilingual Education) was designed as a demonstration program to encourage school districts to expend an increased amount of funds from other sources, including Title I funds, on bilingual/bicultural programs. However, apparently just the existence of Title VII (not necessarily the availability of funds) has put a damper on the use of Title I and other funds for bilingual purposes, so that the result of the existence of Title VII (at current levels of funding) may be a net decrease in the amount of funds actually committed to bilingual and bicultural programming. (III G.1)

2. Title VII has funded only three Asian-American programs, all Chinese, despite the fact that there is a substantial and increasing immigration of non-English speaking Filipinos and Koreans to this country. (III G.2)

3. As a demonstration project, Title VII should be funding a wide variety of programs in order to stimulate bilingual/bicultural programs in the whole range of educational services that are important to ethnic minorities. But it has not funded any child development, vocational education, or adult education programs, although provisions for such programs are made in the legislation. (III G.3)

L. Vocational Education

1. Despite the clear intent in legislation and guidelines that the Vocational Education 15% set-aside provisions be used to supplement rather than supplant the regular vocational education program, such funds have been used consistently to pay the full cost, (i.e., supplant) of all vocational education for "the disadvantaged". (III F.1)

2. Although the vocational education guidelines and the State Plans clearly emphasize the need for programs for those who are "culturally different" and particularly those with language difficulties, the evidence indicated: (a) the absence of culturally relevant curricula necessary for effective programming for many ethnic minority individuals; (b) little or no special planning for ethnic individuals; (c) that ethnic individuals are not receiving their fair share of services under

the program. Special programs for the disadvantaged were often indistinguishable from the regular Vocational Education Program. (III F.4)

M. Rehabilitation Services Administration

1. The Rehabilitation Services Administration spends substantially less for Black clients for every type of service it provides. While detailed data on ethnic minorities are not kept by RSA, evaluations of individual programs serving ethnic minorities indicate the same lower level of service and expenditures. Further study is essential.

N. Conclusion

Phase I found no evidence that HEW administrators intend to be unresponsive to deficiencies in programs serving the ethnic minorities. Lack of information, oversight, insufficient sensitivity and lack of advocacy, however, can accomplish the same ends. The overall impression obtained in Phase I was not that program planners and administrators willfully disregarded the ethnic minorities -- it appeared that, more than not, they overlooked them. Phase I led the researchers to conclude that HEW does have an "informal" policy of advocating program planning that is specifically responsive to the ethnic minorities (including the design of culturally responsive program services). However, the overwhelming impression is that for the most part this policy is informal, and being such, has never been fully communicated and/or interpreted to program offices, and, therefore, never effectively implemented.

A formal commitment by HEW to serve ethnic minorities, followed by the support and administrative direction necessary for carrying out such a policy, should enable ethnic minorities to begin to raise their low levels of health, education and welfare status which pervade each of the ethnic groups and subgroups.

However, there is an even more important issue -- from the point of view of the ethnic minorities. Bilingual/bicultural programs are not simply devices to get ethnic minority children to achieve better in school; similarly culturally sensitive health services for the ethnic minority elderly have more at stake than just improving their health, though that is a most vital objective. Such programs and services are essential to the very survival and perpetuation of the ethnic culture and values, and thereby essential to the individual's self-respect and the right of each citizen to choose the way in which he wishes to live his life. A culturally sensitive program converts a negative view of characteristics as "deficiencies" or "barriers" which have to be eliminated or overcome (often portrayed by insensitive program planners), to their original role as sources of pride and self-respect. In this context, the individual is no longer forced to choose between retaining his culture and succeeding in American society.

We have become increasingly aware of the value of pluralism in our society, not just because of the richness it contributes to all our lives, but also because it secures the rights of the individual and groups to survive culturally. Within certain limits, a free society presumes the right of each

person to choose the way of life he or she finds most meaningful. For ethnic minority persons, bilingual/biculturally-oriented services provided by HEW can make this right more of an actuality than an ethereal ideal.